APPENDICES

7.01 Appendix A - Glossary of Terms

Acronym	Definition
.NET	Microsoft's application development framework for Web, server and Smart Client applications.
AB	Aid to the Blind
Access	PC-based database management system and application development language, made by Microsoft, that assists with the transfer of data into reports, invoices, etc.
Ad Hoc Report	A report produced for a particular purpose and not intended to become a permanent reporting requirement; claim detail reporting in support of SURS is a part of normal SURS operations and is not included as an ad hoc report.
ADA	American Dental Association
Adjudicated Claim	A claim that has reached final disposition such that it is either to be paid or denied.
Adjustment	A transaction that changes any information on a claim that has been adjudicated.
Agency	Alabama Medicaid Agency
AMAES	Alabama Medicaid Application and Eligibility System (Recipient Eligibility)
AMMIS	The Alabama Medicaid Management Information System (AMMIS) consists of all subsystems of the AMMIS except the Recipient Subsystem.
ANSI	American National Standards Institute, an accepted standards-setting body for the computer industry.
APD	Advance Planning Document
API	Application Program Interface
AR	Accounts Receivable
ASC	Ambulatory Surgical Center
ASCII	American Standards Code for Information Interchange
AVECS	Automated Voice Eligibility and Claims System
AVRS	Automated Voice Response System
BENDEX	Beneficiary Earnings Data Exchange system; a file containing data from CMS regarding persons receiving benefits from the Social Security Administration.
Bidder	The corporation, partnership, or joint venture (including any and all subcontractors proposed thereby) that submits a timely, complete, and correctly formatted proposal in response to this ITB
Bill	As refers to a bill for medical services, the submitted claim document, or EMC record; may contain one or more services performed.

Acronym	Definition
Business Days	Official hours of operation based on a five (5) day workweek, excluding Saturdays, Sundays, and official state holidays.
Buy-In	A procedure whereby the State pays a monthly premium to the Federal government on behalf of eligible medical assistance clients for Medicare Part B coverage and to purchase Medicare Part A coverage for a limited number of recipients meeting State-defined criteria.
Capitated Service	Any Medicaid-covered service for which a provider receives a capitated payment.
Capitation	A contractual arrangement through which a health plan or other entity agrees to provide specified health care services to enrollees for a specified prospective payment per member, per month.
Capitation Rate	The amount paid per member, per month for services provided at risk.
CASE	Computer-Aided Software Engineering
Case Management	Gatekeeping: in the primary medical provider program and for long-term care, including assessment, brokering, and monitoring of services.
CASS	USPS form #3553
CD	Compact Disk
CFR	Code of Federal Regulations
Checkwrite	Semi-monthly financial adjudication cycle
CLIA	Clinical Laboratory Improvement Amendments of 1988; a federally mandated set of certification criteria and a data collection and monitoring system to ensure proper certification of clinical laboratories.
CMS	Centers for Medicare and Medicaid Services, formerly HCFA
CMS-1500	CMS approved claim form used to bill professional services, formerly HCFA-1500
CO	Change Order
COLD	Computer Output to Laser Disk
Contract	Referring to the written, signed agreements resulting from the ITB, for the implementation and operation of an MMIS and fiscal agent services for the State of Alabama, unless context clearly requires otherwise.
Contract Amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract; it shall include bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.

Acronym	Definition
Cost Avoidance	The payment methodology of avoiding part or all of Medicaid's payment when a third party resource is available to pay a claim.
COTS	Commercial Off the Shelf
CPHA	Committee on Professional and Hospital Activities, which submits update tapes to the states for ICD-9-CM
CPT	Common Procedure Terminology
CPU	Claims Processing Unit
CROCS	Comprehensive Recipient On-line Collection System
CSR	Customer Service Request
Days	See business days
DBA	Doing Business As
DBMS	An integrated (object-oriented or relational) comprehensive database management system, including all data and all internal and linked databases.
DDI	Design, Development, and Implementation
DEA	Drug Enforcement Agency
DEERS/TriCare	Defense Enrollment Eligibility Reporting System/TriCare
DHR	State of Alabama Department of Human Resources
Deliverable	A product of a task milestone or MMIS requirement.
DESI	Drug-Effectiveness Source Identifier
DPH	State of Alabama Department of Public Health
DIS	Detailed Implementation Schedule
DME	Durable Medical Equipment
DMERC	Medicare Durable Medical Equipment Regional Carrier – provides the durable medical equipment crossover file
DMH/MR	State of Alabama Department of Mental Health/Mental Retardation
Drug Data Warehouse	Data base of drug prices and other drug related information used by the AMMIS. Currently First Data Bank supplies the drug data warehouse information.
DSD	Detailed System Design document
DSS	Decision Support System
DTL	Detail
DUR	Drug Utilization Review
DUR Board	The State's Drug Utilization Review Board, composed of physicians, pharmacists, and others experienced in drug therapy problems; the Board makes recommendations to the Alabama Medicaid Agency on DUR policies and procedures
DVD	Digital Video Disk
DYS	State of Alabama Department of Youth Services
ECM	Electronic Claims Management
ECS	Electronic Claims Submittal
EDB	Enrollment Data Base
EDI	Electronic Data Interchange

Acronym	Definition
EDS	Electronic Data Systems, the current Medicaid fiscal agent Vendor for Alabama
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EIS	Executive Information System
Eligibility Files	The files which contain Medicaid recipient eligibility data. The Master Eligibility File (AMAES) is currently maintained by Medicaid on the ISD mainframe. An extract from this file is transferred nightly to the Vendor. The Vendor currently loads this file by original Medicaid number to create the Recipient Eligibility File for use in processing claims.
EMC	Electronic Media Claims
Encounter	A record of a medically related service (or visit) rendered to a Medicaid recipient who is enrolled in a participating health plan during the date of service; it includes (but is not limited to) all services for which the health plan incurred any financial responsibility.
Encounter Data Claim	A claim submitted by a coordinated care provider for the actual provider of service to plan enrollee. These claims go through full adjudication to determine payment, if any, which would have been made if the recipient had not been under the plan. On the provider's remittance advice these claims show as denied for plan coverage.
EOB	Explanation of Benefits
EOMB	Explanation of Medical Benefits
EOP	Explanation of Payments
ETG	Episode Treatment Grouper
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment for medical, dental, vision, and hearing services.
ETL	Extract Transform and Load
EVS	Electronic Verification System for verifying eligibility
FDB	First Data Bank - a private firm supplying drug prices and other information to the AMMIS.
FEIN	Federal Employee Identification Number
FFP	Federal Financial Participation; a percent of State expenditures to be reimbursed to the State by the Federal government for medical services and for administrative costs of the Medicaid program.
FFS	Fee-For-Service
FIPS	Federal Information Processing Standards
FIPS PUB	Federal Information Processing Standards Publication
Financial Cycle	The processing of claims from adjudication to payment. A financial cycle includes the updating of financial history and the preparation of provider payments and remittance advices.

Acronym	Definition
	Actual release of payments is not considered part of the financial cycle.
Fiscal Year (Federal/State)	October 1 - September 30
FMAP	Federal Medical Assistance Percentage
FP	Family Planning
FQHC	Federally Qualified Health Center
FY	Fiscal Year
FYTD	Fiscal Year To Date
GIS	Geographic Information System software package (e.g. GEOACCESS). A software package that allows geographical information to be displayed using maps.
GUI	Graphical User Interface. A graphical user interface is a "point and click" interface to a program composed of menus, dialog windows, push-buttons, etc.
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding System; a uniform health care procedural coding system approved for use by CMS, describing the physician and non-physician patient services covered by the Medicaid and Medicare programs and used primarily to report reimbursable services provided to patients.
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services. Refers to U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health Insurance Premium Payment
HIS	Health Information System
HIT	Health Information Technology
HL7	Health Information 7 (Standards for exchanging medical information)
HMOs	Health Maintenance Organizations
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICF-MR	Intermediate Care Facilities for the Mentally Retarded; services are covered for those who are mentally retarded or who have related conditions.
IIS	Information Internet Server
I/S	Alabama Medicaid Information Systems Division
ISD	Alabama Finance Department Information Services Division
IT	Information Technology

Acronym	Definition
ITB	Invitation to Bid
ITF	Integrated Test Facility; allows the Agency and Vendor to monitor the accuracy of the MMIS and to test proposed changes to the system by processing test claims and other transactions through the system without affecting normal operations.
IV&V	Independent Verification and Validation
JAD	Joint Application Design
JCAHCO	Joint Commission on the Accreditation of Health Care Organizations
JCL	Job Control Language
Key Date	A specified date which, if not met, may jeopardize the operations start date.
LAN	Local Area Network
LHW	Living at Home Waiver
Lock-In	A recipient who has been identified as abusing the Medicaid program may be restricted, or "locked-in," to a specified physician and pharmacy. The recipient's eligibility record will indicate that the recipient is restricted. Only claims from the specified providers shall be paid, except as otherwise authorized by Medicaid.
LTC	Long-Term Care, used to describe institutional-based services such as nursing facility and ICF/MR facility care.
MAC	Maximum Allowable Charge for drugs
Managed Care	A comprehensive approach to the provision of health care that combines clinical services and administrative procedures with an integrated, coordinated system to provide timely access to cost-effective primary care and other medically necessary services.
MARS	Management and Administrative Reporting System of the AMMIS
MCS	Managed Care Systems (MCS) refers to the following type of programs: capitated; Primary Care Case Management (PCCM); Prepaid Inpatient Health Plans (PIHP); Maternity Care, Plan 1st and premium payment , etc.
Manual Check	A check issued by the fiscal agent which is not routinely generated by the system during a financial cycle.
Medicare Buy-In	See Buy-In
MEQC	Medicaid Eligibility Quality Control
MH	Mental Health
MITA	Medicaid Information Technology Architecture
MLIF	Medicaid for Low Income Families
MMA	Medicare Modernization Act of 2003
MMIS	Medicaid Management Information System
MR/DD	Mentally Retarded / Developmentally Disabled

Acronym	Definition
MS	Microsoft or Mississippi
MSIS	Medicaid Statistical Information System
Must	Indicates a mandatory requirement or condition to be met; see "shall" and "will"
n-tier	Multi-tier application architecture
NCPDP	National Council for Prescription Drug Programs (current standard is 5.1 but is changing in the near future to D.0)
NDC	National Drug Code; a generally accepted system for the identification of prescription and non-prescription drugs available in the U.S.
NPI	National Provider Identifier
NDM	Network Data Mover
NET	Non-Emergency Transportation
NF	Nursing Facility; a long-term care facility licensed under State law and certified by Medicare to provide skilled and intermediate levels of care.
Objection	An unwillingness to accept or acknowledge a mandatory requirement.
OBDC	Open Database Connectivity
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of the Inspector General
On-Line	Use of a computer terminal with visual display to immediately access computer files.
OSCAR file	CLIA file and updates from CMS
OSI	Open Systems Interconnection
PA	Prior Authorization
PAC	Provider Assistance Center
PAR	Prior Authorization Request
Part A	Medicare coverage which typically pays for inpatient hospital expense.
Part B	Medicare coverage which typically pays for outpatient healthcare expense including doctor fees.
Part D	Medicare prescription drug plan
PASARR	Preadmission Screening and Annual Resident Review
Pass-through Expenses	Those expenses of the Vendor which are to be reimbursed at cost by Medicaid.
Patient Liability	Monthly income of a recipient in a long-term care or inpatient setting for more than thirty (30) days which must be applied to cost of care before Medicaid payment is made
PBRHC	Provider Based Rural Health Clinic
PC	Personal Computer
PCCM	Primary Care Case Management
PEC	Post Extended hospital Care
PETI	Post Eligibility Treatment of Income

Acronym	Definition
PIHP	Prepaid Inpatient Health Plan
PMF	Provider Master file
PMP	Primary Medical Providers
POS	Point-Of-Service/Sale (also place of service on claims)
PRO	Peer Review Organization
Processed Refund	The correction of claim history performed in accordance with the instructions attached to a provider refund check.
Pro-DUR	Prospective Drug Utilization Review
Protest	A complaint about a governmental action or decision brought by a prospective Bidder to the appropriate administrative section with the intention of achieving a remedial result.
QA	Quality Assurance
QC	Quality Control
QDWI	Qualified Disabled Working Individual
QMBs	Qualified Medicare Beneficiaries; Medicare Part A beneficiaries whose income is under one hundred percent (100%) of the poverty level but whose income or assets are too high to qualify for other regular Medicaid benefits.
QWDI	Qualified Working Disabled Individual
RCC	Recipient Call Center
Refund	A repayment made by a provider, usually needed because of an error in billing, receipt of a late insurance payment or a duplicate payment which resulted in an overpayment by Medicaid for services rendered.
RDD	Requirements Definition Document
RDS	Recipient Data Sheet
RDT	Requirements Definition Task
REOMBs	Recipient Explanation Of Medical Benefits
RA	Remittance Advice
Returned Claim	A claim which is returned to the provider prior to entry into the system due to lack of clean claim data or a claim which is returned after deletion.
RHC	Rural Health Clinic
RID	Recipient Identification Number
RPF	Recipient Policy File
RSD	Requirement Specifications Document
RTM	Requirements Traceability Matrix
RTP	Returned To Provider
SAIL	State of Alabama Independent Living Waiver
S-CHIP	State Children's Health Insurance Program
SDX	State Data Exchange System; the Social Security Administration's method of transferring SSI entitlement information to the State.
Shall	Indicates a mandatory requirement or condition to be met; see

Acronym	Definition
	"must" and "will"
SLIMB	Specified Low-Income Medicare Beneficiary; Medicare Part A beneficiaries under one hundred twenty percent (120%) of the Federal poverty level who have income or assets that are too high to qualify for regular Medicaid benefits.
SMM	State Medicaid Manual
SNF	Skilled Nursing Facility; an institution (nursing facility) licensed under State law and certified by Medicare to provide skilled nursing and rehabilitative services.
SOA	Service Oriented Architecture
SOBRA	Sixth Omnibus Budget Reconciliation Act
SOW	Statement of Work
SQL	Structured Query Language for the definition, organization, and retrieval of data in a database management system (DBMS), including the tools for transaction, management, data integrity, and data administration.
SSA	Social Security Administration of the Federal government
SSI	Supplemental Security Income
SSL	Secure Sockets Layer
SSN	Social Security Number
State	The State of Alabama; refers to policies, decisions, procedures, receipt of data, and the like that are defined by Alabama State agencies.
State Plan	The State Plan for Medical Assistance of the State of Alabama as approved by HHS for federal financial participation under Title XIX of the Social Security Act, as amended.
Subcontractor	Any and all corporations, partnerships, agents, and/or individuals retained by the Vendor (with prior written approval from the State) to perform services under this ITB, regardless of the amount, duration, or scope of the services provided and regardless of whether identified in the Vendor's proposal in response to this ITB or subsequently retained during the contract term.
SURS	Surveillance and Utilization Review Subsystem; a federally-mandated MMIS subsystem that builds a statistical base for health care delivery and utilization pattern profiles for both providers and recipients and generates a listing of potential abusers for review by the Alabama Medicaid Agency.
TANF	Temporary Aid for Needy Families
TCM	Targeted Case Management
Title IV-E	The title of the Social Security Act which is an entitlement program providing Federal financial participation for the costs of foster care maintenance and adoption assistance payments.
Title XIX	Of the Social Security Act enacted Medicaid in 1965;

Acronym	Definition
	synonymous with Medicaid
Title XVIII	Of the Social Security Act (Medicare)
TPL	Third Party Liability
TPR	Third Party Resource
TFQ	Together for Quality
TQM	Total Quality Management
UB-04	Standard claim form developed by National Uniform Billing Committee (NUBC) used to bill institutional services.
UPIN	Universal Provider Identification Number
USPS	United States Postal Service
VANs	Value Added Networks
Vendor	Bidder with whom the State has successfully executed a contract under this ITB. Fiscal Agent may refer to Vendor within this document.
WAN	Wide Area Network
WBS	Work Breakdown Structure
WIC	Women, Infants, and Children's program
Will	Indicates a mandatory requirement or condition to be met; see "must" and "shall"
Working Days	See Business Days
Workshops	General statewide training sessions conducted by the Vendor to educate providers regarding proper billing procedures.
YTD	Calendar Year-To-Date

NOTE: Other terms referenced in this ITB shall comply with definitions contained in applicable state and federal laws and regulations.

7.02 Appendix B - Forms

7.02.01 Attachment 1 - Implementation Contract

Implementation Contract

State of Alabama
Montgomery County

KNOW ALL MEN BY THESE PRESENTS, that the Alabama Medicaid Agency, an Agency of the State of Alabama, and the undersigned Vendor agree as follows:

Vendor shall furnish all labor, equipment, and materials and perform all of the work required for implementation activities under the Invitation to Bid, No. 10-X-2205737 dated February 2010, strictly in accordance with the Invitation to Bid's requirements and the Vendor's bid response.

Vendor shall begin performance of implementation activities in accordance with the schedule outlined in Section 2- Statement of Work of the Invitation to Bid.

Vendor shall be compensated for performance of these implementation activities in accordance with the schedule outlined in Section 6.09 and Pricing Schedule B of the Invitation to Bid.

This contract specifically incorporates by reference the said Invitation to Bid, any amendments thereto, and Vendor's bid response, including all attachments.

Vendor

_____
Title

_____
Vendor's Legal Counsel

APPROVED

_____
Finance Director, State of Alabama

Alabama Medicaid Agency
This contract has been reviewed for and
is approved as to content.

_____
Commissioner

This contract has been reviewed for legal form and complies with all applicable laws, rules, and regulations of the State of Alabama governing these matters.

_____
Medicaid Legal Counsel

APPROVED

_____
Governor, State of Alabama

7.02.02 Attachment 2 - Operations Contract

Operations Contract

State of Alabama
Montgomery County

KNOW ALL MEN BY THESE PRESENTS, that the Alabama Medicaid Agency, an Agency of the State of Alabama, and the undersigned Vendor agree as follows:

Vendor shall furnish all labor, equipment, and materials and perform all of the work required under the Invitation to Bid, No. 10-X-2205737, dated February 2010, strictly in accordance with the requirements thereof and Vendor's bid response thereto.

Vendor shall be compensated for performance under this contract in accordance with the provisions of Section 6.09 and Pricing Schedules C and D.

This contract specifically incorporates by reference the said Invitation to Bid, any amendments thereto, and Vendor's bid response, including all attachments.

Vendor	Alabama Medicaid Agency This contract has been reviewed for and is approved as to content.
_____ Title	_____ Commissioner
	This contract has been reviewed for legal form and complies with all applicable laws, rules, and regulations of the State of Alabama governing these matters.
_____ Vendor's Legal Counsel	_____ Medicaid Legal Counsel
APPROVED	APPROVED
_____ Finance Director, State of Alabama	_____ Governor, State of Alabama

7.02.03 Attachment 3 - Intent to Bid Notification

Intent to Bid Notification

INTENT TO BID

ITB #10-X-2205737

This sheet acknowledges that _____ (company name) intends to bid on ITB #10-X-2205737.

COMPANY NAME

_____

REPRESENTATIVE'S NAME

_____

COMPANY ADDRESS

_____

_____

Phone: _____

FAX: _____

E-mail: _____

Date: _____

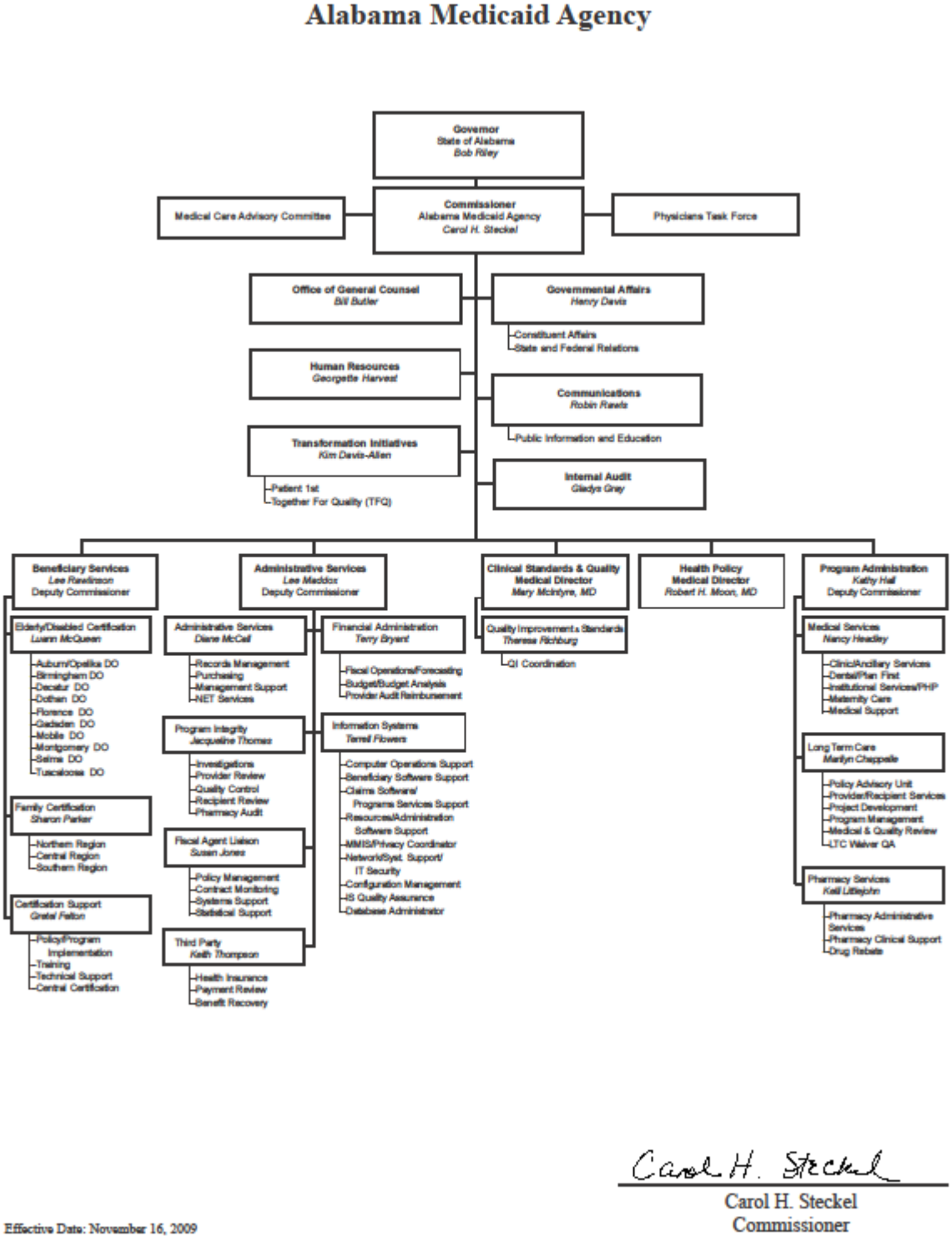
7.03 Appendix C - Overview of MMIS Recipient Subsystem

The following is provided by the Information Systems Division of the Alabama Medicaid Agency to describe our current Recipient Processing Subsystem:

SUBSYSTEM	MAJOR FUNCTIONS/DESCRIPTIONS:
Alabama Medicaid Application and Eligibility System (AMAES)	File contains at least five (5) years of data on approximately 1.2 million Medicaid eligibles including those certified by the Social Security Administration (SSA), Department of Human Resources (DHR), Department of Youth Services (DYS), and detailed data on all applications processed by the Medicaid District Offices and SOBRA Outstation locations. This file is updated by the following processes: batch programs, daily data files from DHR and SSA, and on-line access at the Medicaid Central office, District offices, outstationed SOBRA workers, and DHR. **MAJOR FUNCTIONS INCLUDE:** 1. Provide on-line software to allow users INQUIRY and UPDATE capability on the AMAES file, Provide STATISTICAL DATA & VARIOUS REPORTS to other in-house Agency users and other state agencies as required, 2. Provide on-line capability to GENERATE VERIFICATION LETTERS for District Office and SOBRA recipients (Letters are generated for banks, tax assessors, nursing homes, SSA, and the Veterans Administration.), 3. Provide capability to generate on-line AWARD, DENIAL and TERMINATION LETTERS for SSA, District Office and SOBRA recipients, 4. Provide capability to generate and calculate on-line BUDGETS for Eligibility determinations and for annual reviews for District Office and SOBRA recipients, 5. Provide DAILY ON-LINE TRANSMISSION OF DATA from Medicaid to our fiscal agent to be used in online claim submission, eligibility

SUBSYSTEM	MAJOR FUNCTIONS/DESCRIPTIONS:
	verification, and claims editing and adjudication, 6. Perform several vital annual processes to the Eligibility File data such as the COLA (COST OF LIVING ADJUSTMENTS).
MEDICARE	This data is maintained on the AMAES file. The Centers for Medicare and Medicaid Services (CMS) supplies monthly BUY-IN data for Alabama's recipients with Medicare Parts A, B and/or D.
BENEFICIARY	The Beneficiary Earnings Data Exchange (BENDEX) File contains data concerning the Social Security payments being made to Alabama Medicaid recipients. This information is updated by electronically transmitted data sent by the Social Security Administration (SSA) and is accessible on-line by the Agency staff.
STATE DATA EXCHANGE (SDX) File	State Data is maintained on the file for Supplemental Security Income (SSI) recipients and is accessible on-line to the agency staff. SSA transmits daily update files of additions and terminations for those SSI recipients eligible for Medicaid in Alabama.
MSIS	The Information Systems Division supplies ELIGIBILITY DATA Files to CMS via Medicaid Statistical (MSIS) Files on a quarterly basis. However, to create this quarterly information, data is collected on a monthly basis from our Eligibility (AMAES) File and combined on these MSIS files.
STATE VERIFICATION EXCHANGE SYSTEM (SVES)	This system provides the data exchange of the Social Security numbers (standard response), Title II (BENDEX) data and Title XVI (SDX) data by overnight direct electronic transmission of all recipients of federally funded aid in order to fully utilize the Social Security Administration's data to help establish eligibility and ineligibility in Alabama. This data as it is received from SSA is on-line accessible to the Agency staff.
PSEUDO SSN SYSTEM	This system is used online by Agency eligibility workers to assign a temporary Social Security Number to a recipient until the recipient receives a valid SSN from the Social Security Administration and Medicaid is notified of that number or until an "unborn child" on our Eligibility File has actually been born and the parent can now apply for eligibility. These "pseudo" numbers are system generated, confirmed by the workers, and permanently tied to the recipient's valid SSN and future data received for that recipient.

7.04 Appendix D - Medicaid Organizational Chart



Carol H. Steckel

Carol H. Steckel
Commissioner

Effective Date: November 16, 2009

7.05 Appendix E - Current Program Statistics

7.05.01 Alabama Medicaid Adjudicated Claims Experience (Line Items)

Invoice Category	FY02	FY08
Nursing Facility	289,585	334,021
ICF	0	0
Inpatient Hospital	89,580	170,884
Outpatient Hospital	2,271,063	3,512,950
Ambulatory Surgical	14,823	21,787
Home Health	158,695	293,204
Family Planning - Inst.	23	1,540
Inpatient Psych Hosp.	3,786	13,997
FP - FQHC	8,428	14,445
Hospital - Other	2,684	276
Sterilization - Hosp.	2,443	4,020
PBRHC	221,663	197,064
MR/DD Waiver (HCBS)	83,060	786
Mental Health Services	1,579,236	1,661,128
ICF-MR Public	5,591	2,953
ICF-MR Private	297	820
Nursing Facility - MD (Mental Disease)	4,410	696
TCM - MI (Mentally Ill)	115,816	87,726
OBRA'87 Waiver	0	0
Substance Abuse	75,681	59,023
E&D Waiver - DPH (HCBS)	92,972	167,506
E&D Waiver - Department of Senior Services (HCBS)	98,835	183,771
E&D Waiver - DHR (HCBS)	0	851,308
MHS/Rehab (DHR)	1,177,922	439
TCM - Adult PSI (Protected Services Individual)	8,157	5,798
TCM - MR Adults	86,929	110,084
Hospice	22,703	9,534
Preventive Health Education	17,303	3,216
Drugs	10,469,896	9,327,393
Family Planning Drugs	54,238	82,181
Homebound Waiver (HCBS)	15,639	23,548
Physicians	5,169,892	6,332,959
Dental	1,025,744	1,844,720
Optometrist	286,667	390,691
Eyeglasses	206,386	264,322
Lab	732,290	958,560
Free Standing Radiology	39,996	96,291
EPSDT	584,021	898,940
Hearing	13,118	7,585
State Lab	368,412	692,605
Family Planning - Physician	23,115	87,121
Family Planning - Clinic	75,928	40,432
Transportation	280,327	333,663

Invoice Category	FY02	FY08
DME	565,644	746,073
Rural Health Clinics	137,389	192,777
Maternity Waiver/Care	27,522	36,138
FQHC	747,541	699,855
Private Duty Nursing	9,322	7,051
Other Practitioner	58,378	123,821
TCM - Handicapped Children	81,253	81,720
TCM - Foster Children	59,320	77,014
TCM - Prenatal	11,172	366
TCM - AIDS	10,014	9,337
Therapists	84,779	114,904
Medical - Other	155,820	153,233
Nurse Midwife	1	2,006
Prenatal Clinics	6,157	526
FP - Preventive Health Education	156	4,521
Sterilizations - Physicians	7,777	6,170
Rehab	0	512
CRNA (Certified Registered Nurse Anesthetist)/Nurse Practitioner	34,364	264,986
Physician Lab & X-Ray	2,428,091	2,325,159
Renal Dialysis Centers	69,490	77,312
Drug Case Management - Clozaril	8,192	520
Family Planning - Lab	20,675	31,683
DME – Drugs	77,653	62,562
TCM - Renal Dialysis	50,459	55,456
Children's Specialty Clinic	11,302	10,519
FP - PBRHC	295	2,453
Clinics – DPH	4090	2,614
FP – RHC	13	1,254
Medicare HMO	87	1,002
FP 1115 Waiver	365,009	551,872
FP 1115 Waiver Education	113,835	157,162
FP 1115 Drugs	5,378	62,776
Total	**30,952,132**	**34,953,341**

7.05.02 Estimates of Run Times, Hardware Requirements, and Languages for the AMMIS

1. Run time for month's processing (Includes items 2 -5): accumulation of items 2-4
   - 575 hours CPU time (Production)

2. Financial cycle:
   - Cycle time: 38 hours

3. MAR cycles:
   - Monthly Cycle time: 30 minutes
   - Quarterly MSIS Cycle Time: 4 hours

4. SUR Quarterly
   - Profiler Cycle time: 124 hours
   - ETG Cycle time: 16 hours

5. Adjudication cycle:
   - The Financial cycle comprises 104 jobs & programs in its execution.

6. Type of operating system:
   - Solaris 10

7. I-0 devices:
   - Connect Direct
     - 1-Dell PE6950 w/Windows 2003 Virtual Server
   - SFTP
     - SUN T2000
     - Solaris 10
   - CPUs
     - 8GB RAM
   - Tape Drive
     - Qualstar M2448SA Tape Drive

8. File sizes: 9 TB allocated

9. Claims processing record size:
   - Length of 1 detail pharmacy txn = 182 kb small record size

- Length of 837I txn (UB02) with 999 details = 271745 kb large record size

10. Largest program size in bytes and average program size:
    - Largest program - 2,074,546 bytes
    - Average program - 33,036 bytes

11. Number of jobs run:
    - Claims - 60 daily, 7 weekly, 9 monthly, 3 quarterly, 12 on request
    - DSS - 2 daily, 11 weekly, 22 semi-monthly, 6 monthly, 34 on request
    - Drug Rebate - 3 daily, 4 weekly, 7 monthly, 24 quarterly, 5 on request
    - DUR - 17 daily, 4 weekly, 56 monthly, 17 yearly, 1 on request.
    - EDI - 28 daily, 5 weekly, 5 monthly
    - Eligibility/Recipient - 36 daily, 10 monthly, 1 yearly, 9 on request
    - EPSDT - 2 monthly, 1 quarterly, 1 yearly
    - Financial - 2 daily, 101 weekly, 17 monthly, 3 quarterly, 6 yearly, 12 on request
    - LTC - 4 daily, 1 monthly, 1 on request
    - Managed Care - 20 daily, 6 weekly, 69 monthly, 1 on request
    - MAR - 18 monthly, 20 quarterly, 39 yearly, 2 on request
    - Prior Authorization - 5 daily, 7 monthly,
    - Provider - 6 daily, 7 weekly, 10 monthly, 1 semi-monthly, 1 quarterly, 2 yearly, 6 on request
    - Reference - 2 daily, 23 weekly, 13 monthly, 10 quarterly, 8 yearly, 5 on request
    - SUR - 2 daily, 42 on request
    - System Wide/Ops - 18 daily, 2 weekly, 3 monthly, 1 quarterly, 2 yearly
    - TPL - 16 daily, 24 weekly, 82 monthly, 3 quarterly, 3 yearly, 16 on request

12. Lines of code: approximately 2,563,013 lines of batch code

13. Languages:
    - C, Pro C
    - C#
    - Perl,
    - .net/asp,
    - Korn Shell and c shell
    - General UNIX utilities such as vi editor, ot sort and sftp.
    - Jil
    - sql
    - JavaScript
    - Ajax
    - html, htm
    - Visual Basic
    - Microsoft Visual FoxPro

14. Electronic Claims Submission Hardware
    - 8-Dell 6850's PowerEdge, as ESX VMWare Host servers
    - 1-Dell 1850 PowerEdge – VirtualCenter server
    - Cisco AS5350XM Universal Gateway (for dial-up purposes)
    - 1 ISDN PRI circuit (for dial-up purposes)

15. Voice Response System Hardware:
    - HP Proliant ML370 Server
    - InterVoice BRITE TRM-520 Server
    - 45 phone lines

16. DSS
    - SUN E25K
    - Solaris 10
    - 12 Processors
    - 80 GB of Memory

17. WEB Server
    - UI Servers
        - 4-Windows 2003 Virtual Server
    - Web Portal
        - 3- Windows 2003 Virtual Servers

7.05.03 Provider Statistics FY 2009

- Provider Education via On-Site Visits - 1,653
- Provider Association Interaction - 10 Annually
- Provider Manuals Update & Distribution - 1 distribution annually
    - (approximately 5500 providers)
- Provider On-Site Workshops - 6
- Provider Bulletin Preparation - 4
- Internal & Agency Staff Training Sessions - 5
- SUR Follow - Up Education - (Included in provider visits)
- Mini-Memo File Updates - 24
- Newly Enrolled Provider Follow - up - (Included in provider visits)
- Telephone Inquiries
    - PAC - 212,557
    - RCC - 556,372
    - ECS - 42,506
    - Reps - 30,630
- Written Inquiries
    - PAC - 401
    - Reps - 7,891
    - EMC - 2058
    - RCC - 85,352 approximately
    - Patient 1st requests - 103,855
    - Returned forms to recipients - 8,482
    - Faxes sent to providers - 1,111
- Claims Adjustments - 24,900
- Refund Processing - 21,852 refund transactions processed
- Provider AVRS - 212,628 transactions annually
- Recipient AVRS - 78,520 transactions annually
- Provider Enrollment (Adds) – 9,708
- Provider File Updates (Changes) – 29,996
- Provider File Rate Updates – 550 (Hospital only)
- Provider File Worksheet Resolution – 11,040
- Paper Claims Receipt & Processing – approximately 1,287,768
- RTP (Return to Provider) Processing – 32,460

- Claim Form Distribution & Tracking – 160,932
- Provider Bulletin Distribution - approximately
    - Mail - 16,923
    - E-mail - 2,168
    - Fax - 944
- REOMBS – approximately 2800 per month

7.05.04 Medicaid Mail Activity

Type of Mail-out	FY 2002 Volume
1099	5,148 annually
REOMBs	2,800 monthly
Provider Manuals	CDROM - 6,850 annually Paper - 84 annually
Provider Bulletins	Mail - 16,923 annually E-mail - 2,168 annually Fax - 944 annually
Explanation of Payments (RAs)	7,800,000 pages annually
Returned to Provider (RTP)	32,460 annually
Provider Correspondence Recipient Correspondence	649,224 annually 80,592 annually

Vendor is responsible for production and complete mail service for entries listed above.

7.05.05 Data Entry and Claims Resolution Statistics Fiscal Year 2009

- Data Entry
    - Paper Claims Entered – approximately 1,287,768
    - Worksheet Resolution – approximately 733,512
    - Resolutions Manual Updates – 12

7.05.06 Reference File Statistics Fiscal Year 2009

- Worksheet Resolution – approximately 550,000
- Prior Authorization File Maintenance – 19,812
- Sterilization Claims Review – 6,780
- Data Sheet Distribution – Approximately 17,000 pages per month
- TPL file maintenance – 11
- Pricing file maintenance - 409
- BPA file maintenance - 1433
- Fund code/financial file maintenance – 2
- Diagnosis file maintenance – 166
- Reference file maintenance – 29

7.05.07 Proprietary Software

With the exception of the Provider Electronic Solutions (PES) product described below, EDS utilizes commercially-available software in the construction and operation of the AMMIS.

7.05.07.01 Provider Electronic Solutions (PES)

PES software enables users to submit recipient eligibility requests, electronic claims, and claim reversals and adjustments on behalf of Alabama Medicaid recipients via batch submissions only. PES is available at no charge to Alabama Medicaid providers. All transmissions are encrypted for security.

Batch submission refers to the sending of the following types of submissions in bulk: eligibility verification requests, claims submissions, claim delete requests, and claims inquiries. A batch may contain one record or many records of a single submission type. These transactions are sent for processing from PES software across the public internet to the Alabama Medicaid Secure Web Portal. AMMIS will process batches and return a response to the Web Portal. Providers re-connect to the Secure Web Portal using PES via the public internet to retrieve their responses. All claim types are available for batch transmission.

PES operates in a Microsoft® Windows™ environment. The software is very user-friendly and features point-and-click functionality and on-line help, just like other Windows applications.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

7.06 Appendix F - Procurement Library Contents

- Alabama Medicaid Administrative Code (see www.legislature.state.al.us/CodeofAlabama/1975/coatoc.htm)
- Alabama Medicaid Annual Reports (see www.medicaid.alabama.gov)
- Alabama Medicaid 2011 MMIS Procurement Quality Assurance Plan
- Alabama Medicaid Hardware for 2011
- Alabama Medicaid TPL Month-end Process Requirements
- Alabama MMIS CSRs
- Alabama MMIS Interface List
- Alabama MMIS Reports Listing
- Alabama MMIS System Documentation
- Appendix G – Incumbent Vendor Pricing Schedules
- Appendix G – Non-Incumbent Vendor Pricing Schedules
- Appendix L – Business Experience Matrix
- AVRS Manual (see Provider Billing Manual)
- Claim Forms and Required Attachments (see www.medicaid.alabama.gov)
- Claim and Prior Authorization Forms (see Provider Billing Manual)
- Current Fiscal Agent Contract and All Amendments
- Current Fiscal Agent Organization Chart
- Data Element Dictionary
- Drug Reference File Fields
- DUR Outcome Reject Codes (see www.medicaid.alabama.gov)
- Electronic Media Claims Specifications (see www.medicaid.alabama.gov)

- Enrollment Forms for Providers (see www.medicaid.alabama.gov)
- Health Care Common Procedure Coding System (HCPCS) Codes (see http://www.cms.hhs.gov/HCPCSReleaseCodeSets/)
- List of the State of Alabama Holidays (see http://info.alabama.gov/calendar.aspx)
- List of Licensure Boards
- Medicaid Covered Services Handbook (see http://www.medicaid.alabama.gov/documents/Resources/4-G_Publications/4G-1_YourGuideToMedicaid.11-08.pdf)
- Provider Billing Manual (see www.medicaid.alabama.gov)
- Provider Bulletins (see www.medicaid.alabama.gov)
- Resolutions Manual

NOTE: All items shall be available on and after Procurement Library opening date. Items listed as paper are only available in paper form. All other items are available on CD/DVD for a reproduction fee of one hundred dollars ($100.00) which includes shipping and handling.

7.07 Appendix G - Pricing Schedules

7.07.01 Incumbent Vendor Pricing Schedules

- Pricing Schedule A(I) - Incumbent Vendor Evaluated Price
- Pricing Schedule B(I) - Incumbent Vendor Enhancement Deliverables Costs
- Pricing Schedule C(I) - Incumbent Vendor Operations Costs
- Pricing Schedule D(I) - Incumbent Vendor Extra Contractual Services

NOTE: MS Excel Worksheets with Tabs for each schedule will be provided separately at the Pre-Bid Conference.

7.07.02 Non-Incumbent Vendor Pricing Schedules

- Pricing Schedule A(N) - Non-Incumbent Vendor Evaluated Price
- Pricing Schedule B(N) - Non-Incumbent Vendor Operations and Enhancement Deliverables Costs
- Pricing Schedule C(N) - Non-Incumbent Vendor Operations Costs
- Pricing Schedule D(N) - Non-Incumbent Vendor Extra Contractual Services

NOTE: MS Excel Worksheets with Tabs for each schedule will be provided separately at the Pre-Bid Conference.

If the Bidder has problems with the numbers linking between schedules, you may request a non – password protected spreadsheet for manual entry.

7.08 Appendix H - Staffing Requirements

7.08.01 Key Personnel

This appendix includes the general responsibilities, minimum qualifications, and start dates for key personnel for the MMIS contract. Requirements are presented in matrices for:

- Implementation Phase Key Personnel
- Operations Phase Key Personnel

Separate individuals shall be named for each key personnel position and must be dedicated to their responsibilities under this contract, full-time and on-site.

Implementation Phase Key Personnel			
Key Personnel	General Responsibilities	Minimum Qualifications	Start Date
Account Manager	Contract administration, project management, scheduling and provision of resources, formal communication and correspondence with the Agency and Quality assurance.	Required: Five (5) years of management experience for government or private sector health care payer; Bachelor's degree; previous experience with Medicaid and MMIS development.	Contract signing
MMIS Implementation Manager	Schedule, coordinate, and manage all MMIS implementation task activities. Manage requirements definitions sessions between the Vendor and Agency staff and schedule task-level activities. Coordinate installation of all communication lines, gateways, routers and associated equipment.	Required: Four (4) years of experience in system design, development, and implementation efforts in a management capacity; recent experience of at least three (3) years with MMIS; Bachelor's degree in computer science, business administration, or related field.	Contract signing

Implementation Phase Key Personnel			
Key Personnel	General Responsibilities	Minimum Qualifications	Start Date
MMIS Systems Manager	Act as primary technical contact with the Agency. Provide day-to-day liaison with the Agency. Hire and train system maintenance and modification staff. Develop and manage procedures for routine maintenance.	Required: Bachelor's degree in computer science, management information systems, or a directly related field and at least five (5) years of supervisory experience in health care systems design, development, and programming with at least three (3) years of recent experience with the MMIS or major components.	Must be employed no later than four (4) months prior to start of operations. Can be the same person as Implementation Manager.
Operations / Claims Processing Manager	Manage and design all procedures to support all claims processing activities. Develop job descriptions. Hire and train claims processing staff.	Required: At least four (4) years of experience managing claims processing operations personnel of which two (2) years must be previous Medicaid or Medicare experience.	Must be employed no later than four (4) months prior to start of operations.
Customer Relations Manager	Primary point of contact for provider enrollment and training, provider setup for electronic claims submission, provider manual development and maintenance and provider inquiry.	Required: At least two (2) years of experience managing customer service for provider/recipient relations functions for a Medicaid program or other health care program and a Bachelor's degree in public administration or a related field.	Must be employed no later than four (4) months prior to start of operations.

Implementation Phase Key Personnel			
Key Personnel	General Responsibilities	Minimum Qualifications	Start Date
EIS/DSS Technical Support	Provide training and support to State staff. Provide assistance with software (e.g. SQL).	Required: Bachelor's degree in computer science, management information systems, or directly related field; two (2) or more years of experience in RDBMS and structured query tools.	Must be employed no later than six (6) months prior to start of operations.

Operations Phase Key Personnel			
Key Personnel	General Responsibilities	Minimum Qualifications	Start Date
Account Manager	Same as indicated for Implementation Phase.	Required: Same as indicated for Implementation Phase.	Must be employed no later than six (6) months prior to start of operations.
Operations/Claims Processing Manager	Manage and coordinate all routine claims processing operations.	Required: At least four (4) years of experience managing claims processing operations personnel of which two (2) years must be previous Medicaid or Medicare experience.	Must be employed no later than four (4) months prior to start of operations.

Operations Phase Key Personnel			
Key Personnel	General Responsibilities	Minimum Qualifications	Start Date
MMIS Systems Manager	Act as primary point of contact with Agency staff for system maintenance and modification. Schedule, coordinate, and report on maintenance and modification activities. Coordinate use of maintenance and modification task personnel resources. Facilitate implementation of system modifications. Maintain communications including communication lines, gateways, routers, and associated equipment.	Required: Bachelor's degree in computer science, management information systems, or a directly related field and at least five (5) years of supervisory experience in health care systems design, development, and programming with at least three (3) years of recent experience with the MMIS or major components.	May be Implementation Manager. Must be named six (6) months prior to start of Operations.

Operations Phase Key Personnel			
Key Personnel	General Responsibilities	Minimum Qualifications	Start Date
Customer Relations Manager	Primary point of contact for provider enrollment and training, provider setup for electronic claims submission, provider manual development and maintenance, and provider inquiry. Coordinate all provider services activities. Act as primary point of contact for activities related to provider enrollment, recertification, and training. Manage production, maintenance, and distribution of provider manuals.	Required: At least two (2) years of experience managing customer service for provider/recipient relations functions for a Medicaid program or other government health care program and/or a Bachelor's degree in public administration or a related field.	Must be named no later than four (4) months prior to start of Operations.

7.08.02 Other Contract Required Personnel

These individuals are listed in the ITB with specified duties for the performance of the contract.

- Quality Assurance Manager
- Customer Relations Staff
- SURS Analyst (Can serve in another capacity)
- TCM Prior Authorization Coordinator (Can serve in another capacity)
- HCPCS Coordinator (Can serve in another capacity)
- Medical Policy Specialist (Can serve in another capacity)
- Medical Policy Analyst – Registered Nurse with certification as a Certified Professional Coder
- Medical Policy Analyst - With certification as a Certified Professional Coder
- Modification Team members
- Systems/Technical Support
- EIS/DSS Technical Support
- Provider Quality Assurance Evaluator
- EMC Coordinator
- Drug Data Warehouse Coordinator

7.08.03 Modification Team

Minimum qualifications for the members of the Modification Team specified in *Section 6.07.02* include:

Senior Systems Analyst - A minimum of one (1) year of experience in system development and four (4) years progressive experience in maintenance and modification, with recent experience of at least two (2) years with an MMIS or other health care claims processing system, and a Bachelor's degree or a two (2) year degree from an accredited technical program.

Programmer Analyst - A minimum of two (2) years of progressive experience in system development, system maintenance and modification, and a Bachelor's degree or a two-(2) year degree from an accredited technical program.

Junior Programmer - A two (2) year degree from an accredited technical program.

Project Analyst - A minimum of three (3) years project analyst or related experience in a support role of both maintenance and modification activities in a health care claims processing system.

Two thousand (2,000) hours of monthly Modification Team programming time shall consist of at least forty percent (40%) Senior Systems Analyst hours and an additional

forty percent (40%) at the Programmer/Analyst level or above. These analysts must be devoted exclusively to the Modification Team. No supervisory tasks shall be included in these hours.

The Vendor shall also provide a minimum of eight hundred (800) hours of project analyst time each month. The project analysts shall support the modification efforts exclusively. These project analysts will be responsible for supporting the definition of the work and business activities and serve as policy area specialist with specialized knowledge of MMIS components.

In addition, in years one and two of the operations phase of the contract the Vendor shall provider the following additional resources over and above all other resource requirements specified in this ITB to assist the Agency in implementing ICD 10 changes:

- 40 hours per month EIS/DSS support,
- 50 hours per month Senior System support,
- 50 hours per month Programmer/Analyst support,
- 125 hours per month Project Analyst staff support,
- 125 hours per month Provider Relations staff.

The activities of these staff shall be solely at the Agency's direction.

7.09 Appendix I - State Technical Architecture

The Agency currently utilizes 2 platforms – our internal Microsoft Windows 2003 Active Directory domain and ISD State Data Center IBM z/800 Model 2066-003 mainframe computer.

Current Mainframe Narrative

Basic functions of the state data center mainframe computer:

1. Serves as a data repository for many of the data files that Medicaid utilizes on a daily basis. The storage medium consists of disk, tape, cartridge, and optical.

2. Provides access to mainframe application and system software.

3. Provides telecommunication link to Medicaid users for access to files, processors, printers, etc. located at the data center.

4. File transfer with EDS in Montgomery, AL and Orlando, FL.

Current Microsoft Windows 2003 Active Directory Domain Narrative

Basic functions of our internal Microsoft Windows 2003 Active Directory domain:

1. Provides Medicaid users access to internal Medicaid applications; such as the Medicaid Personnel System, Accounts Payable System, Security Awareness Training, etc.

2. Provides authentication and authorization for domain resources.

3. Provides basic file and print services for Medicaid users.

Current Wide Area Network Narrative

Basic functions of the Agency Wide Area Network:

1. Provides access between the nine (9) remote district offices with access to our local area network.

2. Provides connectivity to the ISD mainframe via the campus ring connection.

3. Provides connectivity to EDS resources at the TechnaCenter location.

4. Provides email, DNS, DHCP, and Internet services.

Current Technical Infrastructure

Main office users access the LAN using TCP/IP over Ethernet. The nine (9) external District Offices access the WAN using TCP/IP over Ethernet via T-1 connections to Medicaid's local AT&T POP. A T-1 connects the local POP to a router at the main office. The main office and district offices access the ISD mainframe through an ISD provided VisualConnect 3270 Emulator web browser application.

LAN/WAN Software Standards

- Microsoft Windows XP & Microsoft Vista 32 Bit
- Internet Explorer 6.0 & 7.0
- McAfee Anti-Virus
- Microsoft Office 2007 (Professional)

LAN/WAN Hardware Standards

- IBM z/800 Model 2066-003 mainframe. We are currently running z/OS 1.9.
- Our disk storage consists of two (2) 10TB IBM 2105 Shark storage subsystems. One is used for production data bases and other data sets. The other IBM 2105 will be used to store virtual tape data.
- Our physical tape storage consists mainly of four (4) StorageTek tape cartridge silos housing both 200MB and 20GB tapes. We plan to migrate to the aforementioned virtual tape system (late summer 2009) and will upgrade our physical tapes to IBM 3592 Model 500GB tapes housed in an IBM 3494 Automatic Tape Library (ATL). Upon successful implementation of the virtual tape system and the ATL the four (4) StorageTek silos will be de-installed.
- We are establishing a Disaster Recovery (DR) data center in the Alabama State House. It will mirror our production data center.
- The ISD mainframe supports both TCP/IP and SNA based data communications and has a web site on the Internet.
- TN3270 access is possible via the Internet with the proper security clearances.
- We run both IMS and CICS based transaction subsystems.
- TCP/IP-based File Transfer Protocol (FTP) is the preferred file transfer platform and secure FTP (SFTP) is available.

Medicaid Hardware

Medicaid DO (District Offices) Switches – Cisco Catalyst 3500XL & Cisco Catalyst 3560

Tablet PC LE1700	
Base Unit:	LE1700
Processor:	INTEL CORE 2 DUO 1.5GHz 8
Memory:	1GB RAM
Keyboard:	
Monitor:	
Video Card:	
Hard Drive:	60GB
Floppy Disk Drive:	
Operating System:	
Mouse:	
NIC:	
CD-ROM or DVD-ROM Drive:	
Sound Card:	
Speakers:	

Notebook Latitude D830	
Base Unit:	Latitude D830
Processor:	INTEL CORE 2 DUO T7300 2.0GHz 8 MHZ 4M CACHE DUAL CORE PROCESSOR
Memory:	2GB RAM DDR2-667 SDRAM 2 DIMM
Keyboard:	Internal English
Monitor:	15.4 INCH WIDE SCREEN WXGA
Video Card:	256MB NVIDIA QUADRO NVS
Hard Drive:	80GB 7200 RPM
Floppy Disk Drive:	FLOPPY DRIVE
Operating System:	Windows XP PRO SP2
Mouse:	TOUCHPAD
NIC:	
CD-ROM or DVD-ROM Drive:	8X DVD +/- RW
Sound Card:	
Speakers:	

Desktop Optiplex GX620	
Base Unit:	OptiPlex GX620
Processor:	INTEL P4 620 W/HT 3.2GHz

Memory:	1GB RAM
Keyboard:	Standard
Monitor:	
Video Card:	VIDEO/Graphics – PCIE 256MB CARD, VGA/DVI ADAPTER, DUAL Monitor 128MB
Hard Drive:	160GB 7200 RPM SATA
Floppy Disk Drive:	None
Operating System:	Windows XP PRO
Mouse:	Dell USB 2 Button Optical Mouse with scroll
NIC:	Integrated 10/100/1000 Ethernet
CD-ROM or DVD-ROM Drive:	Optical Drive Combo CD-RW/DVD-ROM
Sound Card:	
Speakers:	Standard Dell

New Desktop Replacements

Optiplex GX760	
Base Unit:	OptiPlex 760 Small Form FactorBase Standard PSU (224-2219)
Processor:	OptiPlex 760,Core 2 Duo E8400/3.0GHz,6M,1333FSB (311-9513)
Memory:	2GB,Non-ECC,800MHz DDR2,2X1GB OptiPlex (311-7374)
Keyboard:	Dell USB Keyboard, No Hot Keys English,Black,Optiplex (330-1987)
Monitor:	No Monitor Selected, OptiPlex (320-3704)
Video Card:	256MB ATI RADEON HD 2400 Pro Single Monitor Graphics w/DVI and TV Out,Low Profile,Dell OptiPlex (320-5740)
Hard Drive:	160GB SATA 3.0Gb/s and 8MB Data Burst Cache, Dell OptiPlex (341-8007)
Floppy Disk Drive:	3.5 inch, 1.44MB, Slimline Floppy Drive,Dell OptiPlex Small Form Factor (341-4611)
Operating System:	Windows XP PRO SP3 with Windows Vista Business License English, Dell Optiplex (420-9570)
Mouse:	Dell USB 2 Button Optical Mouse with Scroll,Black OptiPlex (330-2733)
NIC:	Intel Standard Manageability Hardware Enabled Systems Management, Dell OptiPlex (330-2902)
CD-ROM or DVD-ROM Drive:	Roxio Creator Dell Edidion,9.0Dell OptiPlex (420-7963)
CD-ROM or DVD-ROM	Cyberlink Power DVD 8.1,with Media, Dell

Optiplex GX760	
Drive:	OptiPlex/Precision (420-9179)
CD-ROM or DVD-ROM Drive:	8X DVD+/-RW,Slimline,OptiPlex Small Form Factor (313-6092)
Sound Card:	Heat Sink, Mainstream, Dell Optiplex Small Form Factor (311-9520)
Speakers:	Dell AX210 two piece stereo Speakers (Black) for Latitude OptiPlex, Precision (313-6515)
Cable:	OptiPlex 760 Small Form Factor Standard Power Supply (330-1984)

Storage Area Network: CX4-480	
Base Unit	Dell/EMC CX4-480
System Cache	16 GB
Storage	Current: 28 TB raw storage Expansion Capability: Up to 216 TB raw storage
RAID Levels	RAID 0. 1. 1/0. 3.5. and 6
Number of Supported Hosts	Up to 256 SAN attached HA connected hosts
Connectivity	8Gbit Fiber Channel and 1 Gbit iSCSI

7.10 Appendix J - Responsiveness Requirements Checklist

This appendix identifies the mandatory responsiveness requirements for proposals. Failure, in whole or in part, to respond to a specific mandatory requirement shall result in rejection of the proposal during the evaluation phase.

GENERAL RESPONSE REQUIREMENTS (as defined in ITB Section 4.01)	RESULTS	
	Pass (Yes)	Fail (No)
1. Was the proposal received by the State of Alabama's Department of Finance, Division of Purchasing by the date and time specified in the Section 1.05 - Schedule of Activities?		
2. Was a notarized State of Alabama "Invitation to Bid" form, signed in ink by the Bidder (or an officer of the Bidder who is legally authorized to bind the Bidder to the proposal) submitted as specified in Section 1.10 - Bidder's Submission?		
3. Were one (1) original and ten (10) copies plus two (2) electronic versions of the proposal, with the Transmittal Letter, submitted with at least one (1) copy containing the required original signatures?		
4. Was a Letter of Intent to Bid submitted by the date and time as specified in Section 1.05 - Schedule of Activities?		
5. Was a bid bond guarantee in the amount of three-hundred thousand dollars ($300,000) submitted in the original hard-copy version of the Bid Response, in the required format as specified in Section 1.25 - Bid Guarantee?		

BID RESPONSE REQUIREMENTS (as defined in ITB Section 4.04)	RESULTS	
	Pass (Yes)	Fail (No)
6. Does the Proposal include seven (7) separate sections and assorted subsections, as described in Section 4.04.02: Tab 1A - Transmittal Letter? Tab 1B - Bid Guarantee (Original Volume Only)? Tab 1C – State of Alabama Invitation to Bid Form and Pricing Schedules - Original Volume Only? Tab 2 - Table of Contents? Tab 3 - Executive Summary? Tab 4 - Approach to Implementation Phase? Tab 5 - Operations Phase? Tab 6 - Corporate Capabilities and Commitments? Tab 7 - Appendix?		
7. Is the Transmittal Letter, on official business letterhead, from the entity submitting the proposal as the prime contractor?		
8. Is the Transmittal Letter signed by an individual authorized to legally bind the Bidder?		
9. Does the Transmittal Letter include a statement addressing each of the items in Section 4.03 – Transmittal Letter numbers 1a-q?		
10. If subcontractors are proposed, has each subcontractor submitted a statement, on official letterhead, signed by an individual authorized to legally bind the subcontractor to perform the scope of work, and addressing each of the items in Section 4.03 – Transmittal Letter numbers 2a-e? If subcontractors are not proposed was there a statement to that effect?		
11. Does the Transmittal Letter explicitly identify and explain where the proposal deviates, in any way whatsoever, from the detailed specifications and requirements in the ITB?		

TABLE OF CONTENTS AND ITB CROSS-REFERENCE (as defined in ITB Section 4.04.06)	RESULTS	
	Pass (Yes)	Fail (No)
12. Is there a Table of Contents with the titles for each section and beginning page numbers?		
EXECUTIVE SUMMARY (as defined in ITB Section 4.04.07)		
13. Is the Executive Summary no more than twenty-five (25) pages in length?		
APPROACH TO IMPLEMENTATION PHASE (as defined in ITB Section 4.04.08)		
14. For each of the six (6) components identified in Section 4.04.08, has the Bidder provided the required information in the order and format specified? • Design and Development Methodology • Products and Deliverables • Implementation Phase and Work Plan • Proposed Staffing • Implementation Phase Contract Management • Commitment to Quality		
APPROACH TO OPERATIONS PHASE) (as defined in ITB Section 4.04.09)		
15. Does the Bidder include a staffing approach for the Operations Phase?		
CORPORATE CAPABILITIES AND COMMITMENTS (as defined in ITB Section 4.04.10)		
16. Is the Corporate Capabilities and Commitments section no more than forty (40) pages long, exclusive of financial statements? And does it contain Corporate Information, Financial Statements, Contractual Disputes and Corporate Commitments?		
17. Did the Bidder complete Appendix L – Business Experience Matrix with a minimum of three (3) references of previous contracts in which the Bidder processed medical claims included in the proposal?		
18. Has the Bidder submitted financial statements?		
PRICING SCHEDULES (as defined in ITB Section 4.04.05)		
19. Is there a signed and completed Pricing Schedule A(I) or A(N)?		
20. Is there a signed and completed Pricing Schedule B(I) or B(N)?		
21. Is there a signed and completed Pricing Schedule C(I) or C(N)?		
22. Is there a signed and completed Pricing Schedule D(I) or D(N)?		
23. Are all the calculations shown on the various pricing schedules accurate?		

7.11 Appendix K - AMMIS Deliverables

- All MMIS software to which Medicaid has ownership, or which has been designed, developed, or installed with federal matching funds, on CD/DVD.

- All production and test data files used in running the MMIS on CD/DVD.

- All imaged documents stored on optical and magnetic disk, including any documents to be purged and a backup copy of the current file(s).

- Job scripts and scheduling information for every production job to include, at a minimum, condition codes, system messages, start and stop dates and times, CPU time used, and clock time on CD/DVD in a format specified by the Agency.

- All other documentation, on CD/DVD, including, but not limited to, user and operation manuals needed to operate and maintain the system.

- Operations logs, process summaries, and balancing documents completed during the contract, in a medium and format specified by the Agency.

- Procedures for updating computer programs, scripts, data dictionaries, and other documentation.

- Job scheduling parameters and/or inputs and reports used by operations staff during routine operations.

- Hardware configuration diagram showing the relationship between all information systems and communication equipment necessary to operate the AMMIS, including, but not limited to: local area networks, EMC support networks, control units, remote job entry devices, data storage and transmission devices, printers, computers, PCs, and data entry devices.

- A description and flow charts showing the flow of major processes and data in each of the MMIS subsystems and across subsystems. This will include but not be limited to a data flow diagram showing data stores and flows.

- Claims that are used for regression testing and to test data entry.

- Data Element Dictionary of all AMMIS tables, attributes and Meta data.

7.12 Appendix L - Business Experience Matrix

NOTE: MS Excel Worksheet will be provided separately at the Pre-Bid Conference.

7.13 Appendix M - Cost Containment Proposal

7.13.01 Cost Containment

The Agency offers the Vendor the opportunity to participate in the management of Agency expenditures during the contract period. The Vendor may propose new and creative ideas for increasing Agency control over the expenditure of program dollars. If accepted and implemented by Agency during the Operations Period, payment shall be made after savings are actually realized. This does not include operational or administrative savings.

7.13.02 Cost Containment Innovations

Throughout the life of this Contract, the Vendor shall propose new and creative ideas that increase the Agency's control over the expenditure of program dollars and result in a savings in Agency program expenditures. The Vendor shall create a unit whose sole function is to work on cost containment proposals and projects. This unit shall be staffed with medical, analytical, statistical, and clerical data processing support staff that shall be provided with necessary computers and administrative support. This unit shall remain in existence for the life of this Contract.

The Vendor shall analyze program expenditures and processing controls, develop new and creative approaches to controlling expenditures, and present those proposals to the Agency.

The Agency, however, retains the sole right of approval of each cost containment proposal and any Agency-approved reductions in expenditures related to fraud, as well as the cost savings methodology on a project-by-project basis throughout the life of the contract. The Agency is not mandated to approve any of the proposed projects. Furthermore, the Agency reserves the sole right to discontinue, by letter, any previously approved project at any time.

Any proposals that are counter to law or regulation will not be accepted. In addition, the Agency will not accept any proposals which, in its sole discretion, are not in the best interests of the Agency, or are not feasible.

Cost Containment innovations that are modifications to an implemented System Development Notice (SDN) design will not be approved.

Cost Containment staff shall be the sole responsibility of the Vendor and not be included under any Agency expense. Cost Containment Staff shall not utilize and/or share responsibilities with other Vendor staff as described elsewhere in this Contract.

7.13.03 Proposals

Once the Agency has accepted a cost-containment proposal the Vendor shall submit to the Agency a suggested methodology for determining the actual savings the proposal will

generate. The Vendor shall submit the methodology to the Agency for review and approval no more than fourteen (14) months from the date the changes were implemented. The Agency shall have sixty (60) calendar days from receipt of the methodology for review and approval. If the Agency does not agree with the suggested methodology, and no agreement can be reached with the Vendor, the Commissioner shall determine the method to be used. Once the methodology is mutually agreed to or determined by the Commissioner, it shall not be subject to dispute.

Payment to the Vendor for implemented cost-containment proposals and/or any reductions in expenditures related to fraud shall be made only after savings are actually realized. The Vendor shall develop reports and submit them to the Agency showing the savings as determined by the established methodology.

7.13.04 Systems Development

The installation of each cost containment proposal shall be initiated through normal change procedures using **change orders written (COWs)**. All cost containment projects requiring programming and/or system updates shall be done by Vendor resources with prior Agency approval. If done by Vendor resources, the Vendor's change order process shall be followed and the results shall become part of the AMMIS. The Vendor costs for the implementation of cost containment proposals shall be considered as billable hours to the Agency at fifty percent (50%) of the bid rate.

If any time after the changes are implemented the Agency should find it necessary to rescind the change or modify the effective date and this change results in the need to reprocess claims previously denied or cutback under the change, the Vendor shall prepare a new methodology and determine the updated savings amounts. The new savings shall be compared to the original savings amounts and a credit issued to the Agency. The cost of system changes shared with the Vendor shall be refunded to Agency if no savings are realized to cover the actual systems cost.

7.13.05 Operations: Cost Containment

Operations constitute all contractual responsibilities required for the Vendor to administer and operate the AMMIS as described in this ITB.

The activities of the Cost Containment Project are non-billable.

When a cost containment proposal is implemented by the Vendor, the Vendor will be paid an administrative fee for that proposal for a period not to exceed two (2) years from the date of implementation. Additionally, the Vendor's costs for implementation of cost containment proposals through the process shall be considered as billable hours to the Agency at fifty percent (50%) of the bid rate.

7.13.05.01 Cost Containment Payment

The payment for Agency approved cost containment projects is based on the Vendor receiving an administrative fee equal to ten percent (10%) of the amount of net program

dollars saved (the actual amount of program dollars saved less development costs) from all projects up to that time.

The payment for billable hours for programming and/or system updates of cost containment proposals shall be at fifty percent (50%) of the hourly rate. The Vendor must show 100% of the hours on the invoice for the project, with fifty (50%) of the hours shown as non-billable. The Vendor shall not submit invoices for any costs related to a cost containment project until such time as the actual net savings are realized as a result of the implementation exceed the total costs incurred by the Vendor. The Vendor must provide sufficient documentation at the time the invoice is submitted to prove the actual savings realized meets or exceeds the total costs for the project. This portion of the invoice will be paid only upon the Contracting Officer's approval of such documentation.

7.13.05.02 Cost Containment Invoicing

Two (2) months after the implementation of each proposal, and monthly thereafter, the Vendor will send a report to the Agency that shows the monthly savings from each cost containment project, and the total monthly savings and total cumulative savings from all cost containment projects that have been implemented within the last two years and are still in operation. The Vendor will invoice the State for ten percent (10%) of the cumulative amount reflected in the reconciled saving report for the month in which the savings exceed two hundred and fifty thousand dollars ($250,000). The Agency will reconcile the invoice and pay the Vendor the full amount earned. **When another $250,000 program dollars** are saved from all projects, the Vendor will invoice again and be paid ten percent (10%) of that cumulative amount reflected in the monthly reconciled savings report for the month in which the savings exceed $250,000. Payment in this manner will continue, except as defined below.

7.13.05.03 End of Contract Payment Adjustments

For those projects implemented in the last two (2) years of contract operations, including any contract extensions and/or the two (2) years prior to a contract termination, the administrative fee shall be adjusted on a pro rated basis so the Vendor will receive a total administrative fee for the project equal to that which the Vendor would have received had the Vendor been able to operate the project for the full two (2) years allowed. In no instance shall the Agency pay a prorated administration fee if the Contract is terminated for cause. In this instance the Vendor shall submit an invoice for ten percent (10%) of the actual savings realized prior to the date of termination.

7.13.05.04 Precedent for Payment

The Agency must approve cost containment proposals, including estimated savings formulas, before the Vendor may commence work. Under no circumstances will the Agency pay the Vendor for savings that result from a cost containment proposal that was not first approved by the Contracting Officer.

7.13.06 Opportunities for Reduction in Operations Costs

The Vendor is encouraged to submit proposals which reduce the operations cost of the AMMIS Contract. These proposals shall be known as Cost Reduction Change Proposals. If approved, a Vendor-initiated proposal will result in a shared savings between the Vendor and the Agency. This Section describes Operations Payment for any work that may occur during Operations due to cost containment activities.

7.13.06.01 Cost Reduction Change Proposal Projects

1. Proposals Related to System Operations -

   When a Cost Reduction Change Proposal Project that affects system operations is implemented by the State, the Vendor will be paid a percentage of the net contract savings according to the percentages set forth below.

   a. If a Cost Reduction Change Proposal is Vendor initiated, net contract savings shall be apportioned seventy-five percent (75%) to the Vendor and twenty-five percent (25%) to Agency. The twenty-five percent (25%) savings shall be applied under Contractor Amendment costs, or, if there are no offsetting changes, the apportioned savings will result in a reduction in contract prices.

   b. If a Cost Reduction Change Proposal results from joint efforts on the part of Agency and the Vendor, net contract savings shall be proportionately shared between the parties, the proportioned shares to be determined through an agreement of the parties. In the event that an agreement on proportioned shares cannot be reached within six (6) months of the date the Agency authorizes the change, the Agency and the Vendor shall each share fifty percent (50%) of the benefits.

2. Proposals Related to Cost Reimbursed Items:

   For Cost Reduction Change Proposals that affect the cost reimbursement portion of the Contract, regardless of whether it was originated by the Vendor or resulted from joint efforts on the part of Agency and the Vendor, net contract savings shall be apportioned between Agency and the Vendor as follows:

Cumulative Savings	Agency Share	Vendor Share
$5,000 - $250,000	50%	50%
$250,001 and above	Percent apportionment negotiable but shall not exceed 50% to the Vendor and shall not exceed a maximum of $500,000 per improvement to the Vendor.	

3. Proposals Originated and Paid for by Agency:

For system improvements originated and paid for by Agency which decreases the operating expenses or costs, or result in one-time decreased expense or cost, the financial benefits of those changes shall be one hundred percent (100%) to Agency and will result in a reduction of the cost or price of the Contract.

Agency costs shall be offset against the savings generated by the Cost Reduction Change Proposal each time such savings are realized until all costs are fully offset. Then, the Vendor's share is calculated by multiplying net contract savings by the appropriate Vendor's percentage-sharing rate). Additional Vendor shares of net contract savings shall be paid to the Vendor at the time savings are realized until the Vendor's share is fully realized.

Documentation of contract savings is the responsibility of the Vendor and is subject to Contracting Officer review and approval prior to payment of the Vendor's share of cost savings as allocated using the apportionment methodology described above. The Vendor will submit a monthly cost savings invoice with appropriate documentation to Agency. The Agency must approve the documentation submitted before payment of the invoice is made. For one-time cost savings, the Vendor will submit a single invoice

7.14 Appendix N - Medicaid Business Associate Addendum

(SAMPLE)

ALABAMA MEDICAID AGENCY
BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (this "Agreement") is made effective the _____ day of _____, 20____, by and between the Alabama Medicaid Agency ("Covered Entity"), an agency of the State of Alabama, and _____ ("Business Associate") (collectively the "Parties").

1. BACKGROUND

a. Covered Entity and Business Associate are parties to a contract entitled _____ (the "Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

b. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule (as defined below).

c. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

Unless otherwise clearly indicated by the context, the following terms shall have the following meaning in this Agreement:

a. "Breach" shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information.

b. "Electronic Health Record" shall mean an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

c. "Electronic Protected Health Information" means Protected Health Information that is transmitted by Electronic Media (as defined in the Security and Privacy Rule) or maintained in Electronic Media.

d. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

e. "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

f. "Personal Health Record" shall mean an electronic record of identifiable health information on an individual that can be drawn from multiple sources and that is managed, shared and controlled by or primarily for the individual.

g. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

h. "Protected Health Information" (PHI) shall have the same meaning as the term "protected health information" in 45 CFR 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

i. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.501.

j. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his designee.

k. "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

l. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 162, and Parts 164, Subparts A and C. The application of Security provisions Sections 164.308; 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations shall apply to a business associate of a covered entity in the same manner that such sections apply to the covered entity.

m. Unless otherwise defined in this Agreement, capitalized terms used herein shall have the same meaning as those terms have in the Privacy Rule.

n. "Unsecured Protected Health Information" is information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals by mean of technology or methodology specified by the Secretary of Health and Human Services in the guidance issued under section 13402(h)(2) of Public Law 111–5.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

a. Use and Disclosure of PHI. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as Required By Law.

b. Appropriate Safeguards. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement. The Business Associate agrees to take steps to safeguard, implement and maintain PHI in accordance with the HIPAA Privacy Rule.

c. Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

d. Report Unauthorized Use or Disclosure. Business Associate agrees to promptly report to Covered Entity any use or disclosure of PHI not provided for by this Agreement of which it becomes aware.

e. Applicability to Business Associate's Agents. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by the Business Associate on behalf of, Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information. The Business Associate agrees to have HIPAA-compliant Business Associate Agreements or equivalent contractual agreements with agents to whom the Business Associate discloses Covered Entity PHI.

f. Access. Upon receipt of a written request from Covered Entity, Business Associate agrees to provide Covered Entity, in order to allow Covered Entity to meet its requirements under 45 CFR 164.524, access to PHI maintained by Business Associate in a Designated Record Set within thirty (30) business days.

g. Amendments to PHI. Business Associate agrees to make any amendment(s) to PHI maintained by Business Associate in a Designated Record Set that Covered Entity directs or agrees to, pursuant to 45 CFR 164.526 at the request of Covered Entity, within thirty (30) calendar days after receiving a written request for amendment from Covered Entity.

h. Availability of Documents. Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, Covered Entity, available to Covered Entity or to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy and Security Rules, within five business days' after receipt of written notice.

i. Documentation of PHI Disclosures. Business Associate agrees to keep records of disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

j. Accounting of Disclosures. The Business Associate agrees to provide to Covered Entity, within 30 days of receipt of a written request from Covered Entity, information collected in accordance with the documentation of PHI disclosure of this Agreement, to permit Covered Entity to respond to a request by an Individual or an authorized representative for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

k. The Business Associate shall maintain a comprehensive security program appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities as defined in the Security Rule.

l. The Business Associate shall notify the Covered Entity immediately following the discovery of a breach of Protected Health Information (PHI).

m. The Business Associate shall provide the Covered Entity the following information when a breach of unsecured protected health information is discovered:

1. The number of recipient records involved in the breach.
2. A description of what happened, including the date of the breach and the date of the discovery of the breach if known.
3. A description of the types of unsecure protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other type information were involved).
4. Any steps the individuals should take to protect themselves from potential harm resulting from the breach.
5. A description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches.
6. Contact procedures for individuals to ask questions or learn additional information, which shall include the Business Associate's toll-free number, email address, Web site, or postal address.
7. A proposed media release developed by the Business Associate.

n. The Business Associate shall obtain Covered Entity approval prior to reporting any breach required by 45 CFR Part 164, Subpart D.

o. The Business Associate shall, after receiving Covered Entity approval, provide the necessary notices to the recipient, prominent media outlet, or the Secretary of Health and Human Services (HHS) to report Business Associate breaches as required by 45 CFR Part 164, Subpart D.

p. Covered Entity will coordinate with the Business Associate in the determination of additional specific actions that will be required of the Business Associate for mitigation of the breach.

q. If the Business Associate is a vendor of personal health records, notification of the breach will need to be made with the Federal Trade Commission.

r. The Business Associate shall be responsible for any and all costs associated with the notification and mitigation of a breach that has occurred because of the negligence of the Business Associate.

s. The Business Associate shall pay all fines or penalties imposed by HHS under 45 CFR Part 160 HIPAA Administrative Simplification: Enforcement rule for breaches made by any employee, officer, or agent of the Business Associate.

t. The Business Associate shall be subject to prosecution by the Department of Justice for criminal violations of HIPAA if the Business Associate obtains or discloses individually identifiable health information without authorization, and shall be responsible for any and all costs associated with prosecution.

4. PERMITTED USES AND DISCLOSURES

Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity;

a. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

b. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that:

   1. disclosures are Required By Law; or

   2. Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 42 CFR 164.504(e)(2)(i)(B).

d. Notwithstanding the foregoing provisions, Business Associate may not use or disclose PHI if the use or disclosure would violate any term of the Contract.

5. REPORTING IMPROPER USE OR DISCLOSURE

a. The Business Associate shall report to the Covered Entity any use or disclosure of PHI not provided for by this agreement immediately from the time the Business Associate becomes aware of the use or disclosure.

b. The Business Associate shall report to the Covered Entity any Security Incident and/or breach immediately from the time the Business Associate becomes aware of the use or disclosure.

6. OBLIGATIONS OF COVERED ENTITY

a. Covered Entity shall notify the Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect Alabama Medicaid's use or disclosure of PHI.

b. Covered Entity shall notify the Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect the Business Associate's use or disclosure of PHI.

c. Covered Entity shall notify the Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR

164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

d. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

e. Covered Entity shall provide Business Associate with only that PHI which is minimally necessary for Business Associate to provide the services.

7. TERM AND TERMINATION

a. **Term**. The Term of this Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.

b. **Termination for Cause**. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

1. Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

2. Immediately terminate this Agreement; or

3. If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

c. **Effect of Termination**.

1. Except as provided in paragraph (2) of this section or in the Contract, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

2. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. GENERAL TERMS AND CONDITIONS

a. This Agreement amends and is part of the Contract.

b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

e. The Parties agree to take such action as is necessary to amend this Agreement from time to time for Covered Entity to comply with the requirements of the Privacy Rule and HIPAA.

IN WITNESS WHEREOF, Covered Entity and Business Associate have executed this Agreement effective on the date as stated above.

ALABAMA MEDICAID AGENCY

Signature: _____

Printed Name: **Paul Brannan**

Title: Privacy Officer

Date: _____

BUSINESS ASSOCIATE

Signature: _____

Printed Name: _____

Title: _____

Date: _____

7.15 Appendix O - Alabama Medicaid 2011 MMIS Procurement Quality Assurance Plan

(The following pages in Appendix O are extracts from the Alabama Medicaid 2011 MMIS Procurement Quality Assurance Plan. A complete copy of the plan can be found in the Procurement Library)

PROJECT OVERVIEW

The 2011 MMIS (Medicaid Management Information System) Procurement project has been tasked with planning for the next MMIS fiscal agency contract and possible MMIS take-over for the Alabama Medicaid Agency. The project started in January 2009 with five team members. The project charter was developed and signed by the end of February 2009.

The 2011 MMIS Procurement project has identified the following major deliverables as requirements, an APD (Advanced Planning Document), and an ITB (Invitation to Bid). The ITB will identify additional deliverables required of the selected bidder. When we complete the ITB, we will help the Agency prepare for the review and evaluation of the vendor proposals. The evaluation of the proposals will determine the vendor selected and enable us to prepare for the MMIS enhancements or take-over with enhancements.

PROJECT QA PLAN PURPOSE

The purpose of this QA (Quality Assurance) Plan is to define the techniques, procedures, and methodologies to be used on the 2011 MMIS Procurement Project. Our ultimate goal is timely delivery of the product that meets the client requirements within project or contract resources. This document provides the methodology and criteria we will use to help ensure that all work is consistent, traceable, and of a high standard.
The goal of our quality assurance plan is to ensure that processes and standards are followed. The use of processes and standards help ensure all products delivered meet all technical requirements and the desired level of quality. The QA procedures defined in this document shall be used to examine all products to determine compliance with processes, procedures, and standards established for the 2011 MMIS Procurement Project.

The 2011 MMIS Procurement project rates quality as the #2 priority in the project. The #1 priority is functionality. We will go the extra step to ensure that our project produces quality products and that the products define the functions requested by the Agency. Note: In this document all documents/deliverable/products will be referred to as a product. The ‘product’ tag does not lessen the importance of any document or deliverable.

QUALITY ASSURANCE METHODOLOGY

In order to accomplish our goals in quality this document will define process and procedures for the QA team. These process and procedures will be streamlined or expanded as necessary to ensure we produce the highest quality work possible. This

document will be a "living" document that is modified throughout the project to reflect the changes or additions that we make to the QA methodology. We (the QA team) must follow the same guidelines that we request others in the project to follow.

We began our journey toward quality with a process for gathering requirements. The original process was quickly modified due to time constraints in the schedule. The process was streamlined and a revised version posted to our document repository SharePoint.

SharePoint is the Agency's document repository. SharePoint provides the capability to retain an infinite number of versions for each document with the creator/modifier name and date for each version. The versioning accommodates drafts, baselines, major and minor releases. This project will require all versions of a document to be retained as well as operator/user making the change and a date and time stamp for the change.

PROJECT QUALITY ASSURANCE

Our quality assurance activities will focus on project monitoring, document versioning, monitoring meetings and traceability. The quality assurance activities will monitor the overall quality in the project. It will be used to monitor communication, follow-through and the processes or procedures used to create products.

PROJECT MONITORING

Project start-up documents and milestone deliverables (such as plans) will be reviewed periodically to verify the document reflects the current state of the project. If the document differs from the state of the project, a QA issue will be opened in the project tracking system. The owner of the document shall be given 10 days to update the product and obtain Agency approval. Once Agency approval is received the QA issue will be updated with the resolution and the issue will be closed (see Quality Issue Tracking for more information). Each product shall have a section that defines how the product will be monitored to ensure defined processes and procedures are followed. The project plans shall be reviewed quarterly to ensure the information is current. The project schedule and other products with constantly changing information shall be reviewed monthly. Any member of the QA team may review a product or request changes/updates to a product at any time. This will allow us to identify changes as they occur and request the product be modified to reflect the project change.

DOCUMENT VERSIONING

SharePoint is the Agency's document repository. SharePoint provides the capability to retain an infinite number of versions for each document with the creator/modifier name and date for each version. The versioning accommodates drafts, baselines, major and minor releases. This project will require all versions of a document be retained. The draft documents (documents that have not received Agency approval) will use a numbering below 1 (V0.75). Once the document has been accepted by the agency the document will become version 1.0. All future changes to the document will be

incremented by .01 until a major change is made to a section in the document. All major changes will increment the version by 1.0. The document must also contain a revision history which follows the Table of Contents within the document. The change history will include date, version, name of person making change, reason for change and sections or pages modified. A QA issue will be opened for all versioning problems. When the problem is corrected, the QA team member will update the QA issue with the resolution and close it.

MONITOR MEETINGS

The QA lead shall be notified at least one business day in advance of all meetings, reviews, work sessions, etc. that pertain to the project. The QA lead or team member will randomly monitor meetings and work sessions. Some of the criteria the QA team will use to review the meeting or work session will include:

- Meeting Structure (suggested structure includes):
    - Agenda
    - Roll call
    - Parking lot
    - Action items
    - Meeting notes
- Meeting productivity (i.e. progress made compared with the man hours expended)
- Meeting findings or observations
- QA action items

The QA team member will complete a one page Meeting Review form for each meeting attended. The meeting review documents will be stored in a folder in SharePoint. The QA lead shall monitor the meeting reviews to ensure the QA action items are complete. This information shall be used in the Quarterly QA report.

The QA action items will be used to identify information that needs to be checked or validated or information that should be shared with the team or another functional area. This will include such things as:

- Verification or review of requirements
- Verification or review of plans
- Information to be shared with other functional areas or team members.
- Questions for meeting facilitator or Agency that need to be handled off-line

The QA team member will open a QA issue for all QA action items identified in the Meeting Review. The issue will be closed with the action item has been completed

TRACEABILITY

A Requirements Traceability Matrix (RTM) will be used to address traceability with the ITB as the originating document. The RTM will follow the requirement from the ITB

through gap analysis, design, development, testing and production. The reverse is also true, the RTM will trace the requirement from production to testing, development, design, gap analysis and back to the requirement in the ITB. The QA team shall validate traceability throughout the project. A QA team member will open a QA issue for all traceability problems identified. The issue will be updated with the resolution and closed when the traceability item has been corrected

QUALITY ISSUE TRACKING

The QA team will use the project issue tracking system to track all issues identified in our reviews. The issue tracking system shall have a method to identify issues directly related to quality. All open quality issues will be reported in the QA quarterly report. If there are quality issues identified before the project issue tracking standards have been established, the team will use an issue tracking spreadsheet located in the SharePoint QA folder. See QA Issue Tracking spreadsheet for an example. If the spreadsheet is used, the open issues will be transferred to the project issue tracking software once it is determined & available.

PROJECT QUALITY CONTROL

Quality control activities are performed throughout the project to verify that project management and the project processes defined in the deliverables are properly maintained, of high quality and meet quality standards. Quality control will use deliverable definition documents, project monitoring and a Quarterly QA Assessment report to accomplish these goals.

DELIVERABLE DEFINITIONS

As part of the project startup, we will require deliverable definition (DD) documents. These documents will contain an outline of the final document with descriptive information for each section of the document. The DD must be approved by the appropriate Agency staff. The DD will provide a better understanding to the Agency and the submitter of the document purpose and content. Each product submitted will be compared to the DD for that product. If the product does not follow the approved DD the product will be immediately rejected. See the Product Rejection section for more information.

QUARTERLY QA ASSESSMENT REPORT

The QA lead will produce a quarterly QA Assessment Report by the 7th business day of the month following quarter end. The report will identify the QA activities for the quarter. It will contain a summary of meeting reviews and an assessment of the projects focus on quality. Other items will be added to the report as identified or requested. See the Quarterly QA Report Deliverable Definition for an example.

PROJECT AUDITS AND QUALITY REVIEWS

The QA team will use audits and reviews to help ensure the quality of the products. The audits will verify the defined process is being followed. The reviews will be used to verify the quality of the product.

PROJECT/PRODUCT AUDITS

The audits will be conducted at least quarterly. The Project Manager or QA lead can request an audit at any time or an audit can be triggered by poor quality products. The goal of the audit is to eliminate rework by finding the root cause of the problem. The root cause may be the project documents, a poor process, a lack of understanding the process or even the creator or reviewer. The QA team auditor shall produce a report for the Project Manager and QA Lead. The report may suggest or necessitate follow-up actions. See Audit Report for example.

All members of the QA team will perform audits. The first audit performed by a team member shall have an experienced member, such as the QA lead, participate in the audit. The responsibility for the audit shall rotate unless a problem area is identified for continuous monitoring. The continuous monitoring assignment shall be made by the PM based on workload. Continuous monitoring will require a QA team member at all meetings, reviews, work sessions, etc. for the specific area identified. The QA member responsible for the continuous monitoring of an area shall produce a weekly report of their findings. The report shall be based on the meeting review form.

PRODUCT REJECTION

When a product is first received by the Agency it shall have a very high level review (a rejection review) before it is passed along to the FPO's/PAC's (Functional Process Owners/Program Area Coordinators) or MMIS core team members. The criteria in the table below will result in immediate rejection of the product submitted. Any comments noted to that point will be returned to the submitter as well as the reason for rejection. If the product passes the product rejection criteria identified below, it will be accepted for review. A product rejected twice (not reviewed, but rejected) shall require a minimum of a 5 day wait before being submitted again – even if this results in the product being delivered late. A product rejected three times or more will be escalated to the PM for possible discussion with the Review Board.

PRODUCT REJECTION CRITERIA

Rejection	Rejection Criteria
Immediate Rejection with one comment only (to identify the error)	Misspelling Another state's name in the product (including properties) Missing submission documentation (review checklist, signatures, etc.)

Rejection	Rejection Criteria
	Product does not follow DD (deliverable definition document) Format problems (TOC not updated page numbers off, etc.) Versioning incorrect (version number is missing or incorrect, product history is not updated or correct, track changes is not available (WORD documents only - Original submission shall have track changes turned on).
Rejection on 1st occurrence with only comments to that point.	Information from another state (does not apply to Alabama) that does not contain the state name. Information from the previous version of the product that is no longer applicable. Missing data (a notation that something needs follow-up, question marks or any other special indicator that data is missing) More than 10 unique comments (the same comment in 10 places will only count as 1 comment)

QUALITY REVIEWS

The Agency shall conduct quality reviews on all products delivered. The deliverables identified in the project plan or any product requested by the Agency will have a group review. Normal deliverables and second reviews (when necessary) will be handled as individual reviews. All products must pass the rejection review before it will be considered for an individual review or a group review. All products submitted for review shall include a review check-list which contains the criteria used to review the product and signatures of all reviewers.

AGENCY STAFF INDIVIDUAL PRODUCT REVIEW

Once the product passes the rejection review, it will be available for Agency staff to review. The documentation manager will identify the product reviewers (the Agency staff requested to review the product). The reviewers will be sent an e-mail notification of the review and if available, a SharePoint workflow will be started. The product to review and an Agency Review Comments (ARC) log will be available in SharePoint. The e-mail and the workflow, if available, will specify the due date for the review. The initial review of a product will be allowed 5-10 business days. The day of submission to

the Agency and return to the vendor will not be included in the review period. The submitter will have the same amount of time to respond to the comments. The follow-up review and response, if required, will be 5 to 7 business days depending on the size of the product. All comments must be closed with the second response. If any comment remains open, a meeting will be scheduled as soon as possible but within 5 days of receipt of the follow-up response. See Agency Review Comments (ARC) for a sample comment log.

AGENCY STAFF GROUP PRODUCT REVIEW

The major milestone deliverables defined in the project plan or any product identified by the Agency shall receive a group product review. This review will occur as a meeting with all applicable Agency staff in attendance. The product will be submitted to the Agency 5 working days before the meeting along with a request for the meeting. The Agency Staff will review the product prior to the meeting and note any comments or concerns. If an Agency invitee cannot or will not attend the meeting, their comments can be presented by a co-worker. If the Agency invitee does not attend or send a co-worker they must reject the meeting or e-mail the meeting coordinator or a designated person, stating they have no comments and approve the product as is. If the Agency invitee or a co-worker cannot attend, but they do have comments on the product these comments can be submitted to the Document Manager or a designated person. The Documentation Manager or designated person will represent the FPO/PAC at the group review meeting. The deliverable or product will be reviewed and modified in a meeting with the result of the meeting being an approved product or deliverable. If approval cannot be obtained during the meeting the meeting facilitator shall assign action items and tentatively schedule a follow-up meeting. The follow-up meeting shall occur within 5 days of the original meeting. If the Agency will still not approve the product during the 2nd meeting, the submitter must take a minimum of 5 days to review the product before rescheduling a review.

QUALITY TEAM ROLES

The table below identifies the roles and responsibilities of the 2011 MMIS core team. The roles and responsibilities of other members shall be defined as they join the project.

ROLES AND RESPONSIBILITIES TABLE

Role	***Responsibilities***
Project Manager Paul Brannan	Review all deliverable definition documents Review all products
Quality Lead Renee LaRosa	Review all deliverable definition documents Review all products Schedule & facilitate all quality review sessions (unless the Agency assigns one person to schedule ALL meetings) Define review criteria Conduct quarterly audit

Role	***Responsibilities***
	Assist QA team with audit preparation Produce quarterly reports
Quality Analyst 1 Clay Gaddis – Procurement	Review all deliverable definition documents Review all products Conduct quarterly audit
Quality Analyst 2 Jo Ann Williams – Training	Review all deliverable definition documents Review all products Develop training material and conduct training sessions Conduct quarterly audit
Quality Analyst 3 Cynthia Taylor – Document Manager	Review all deliverable definition documents Review all products Distribute and track all documents for review Conduct quarterly audit

QUALITY PLAN APPROVALS

Quality Plan Developer – Renee LaRosa _____ Date _____

QA Analyst – Clay Gaddis _____ Date _____

QA Analyst – Jo Ann Williams _____ Date _____

QA Analyst – Cynthia Taylor _____ Date _____

Project Manager – Paul Brannan _____ Date _____

QA Plan (APPENDIX A) - MEETING REVIEW FORM

Meeting Name:	Meeting Date:	
QA Team Member:	Meeting Location:	
Meeting Facilitator:		
1. Did the meeting start on time?	Yes	No
2. Was an agenda published one day prior to the meeting?	Yes	No
3. Did the facilitator call roll?	Yes	No
4. Did the facilitator move unscheduled items to a parking lot?	Yes	No
5. Did the facilitator follow the agenda?	Yes	No
6. Did the facilitator complete the agenda?	Yes	No
7. Did the facilitator identify action items?	Yes	No
8. Did the facilitator review the action items & due date at the end of the meeting?	Yes	No
9. Did the facilitator schedule follow-up on parking lot items?	Yes	No
10. Was the meeting productive?	Yes	No
11. Were meeting notes distributed to attendees within 2 days following the meeting?	Yes	No
Comments or Recommendations:		
QA Action Items:		

QA Plan (APPENDIX B) – AUDIT REPORT

Auditor:	Report Date:
Audit for: *(identify specific product reviewed)*	Project Reference Document(s): *(Project documents reviewed to identify process)*
Audit Date:	Audit Process: (*identify the steps in the audit – meetings, reviews, interviews, etc*)
Documented Process: *(Complete this area before the audit. This will be used to outline the process defined in the project documents – strike through any steps not executed during the audit*)	
Findings: *(Document the findings – steps taken that are not in project document, problems, etc.)*	
Recommendations: *(document any recommendations to the Project Manager)*	
Results of Audit: __ Pass __ Process correction required __ Project Documentation correction required __ Did not follow Process with below quality results	Process Followed: Yes No Results Satisfactory: Yes No
Audit Results Explanation: *(Justification for the results of audit selected)*	

QA Plan (APPENDIX C) – AGENCY REVIEW COMMENTS

Alabama Medicaid Agency						
Review Comment Responses and Resolution						
Author:						
Reviewer:						
Version					V 0.01	
Due Date:					**12/31/2099**	
Comment Number	**Reviewer**	**Page #**	**Section #**	**Text**	**Comment**	**Response**

Note: ARC logs will not contain blank lines or merged cells. This will enable the use of filters. The format of the document shall not be altered except by the Document Manager

QA ISSUE TRACKING SPREADSHEET

2011 MMIS Procurement
QA Issue Tracking Spreadsheet

QA Issue number	Qa Team Member	Date Opened	Issue Source	Issue Description	Resolution	Issue date closed
0	*(name of QA team Member)*	*(date issue is opened)*	*(name of document or meeting)*	*(description of the issue)*	*(description of the resolution)*	*(date issue is closed)*
1						
2						
3						
4						
5						

QUARTERLY QA REPORT DELIVERABLE DEFINITION

QA Activities for the Quarter

QA Summary

This section will be used to give a project overview in relation to our quality goals.

Project Monitoring

Project Plans Reviewed

This section will identify all project plans reviewed and any findings or actions taken.

Project Schedule Reviewed

This section will give a summary of the QA review of the project plan.

Project Documents & Versioning

Project Documents Reviewed

This section will identify all project documents reviewed and any findings or actions taken.

Document Versioning

This section will identify any document versioning issues

Monitor Meetings

This section will identify meetings attended. It will also note any issues identified during the meeting.

Project Traceability

This section will identify any document traceability issues

Quality Issues

This section will contain all the open quality issues.

7.16 Appendix P - Disclosure Statement

State of Alabama
Disclosure Statement
(Required by Act 2001-955)

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP TELEPHONE NUMBER ( )

STATE AGENCY/DEPARTMENT THAT WILL RECEIVE GOODS, SERVICES, OR IS RESPONSIBLE FOR GRANT AWARD

ADDRESS

CITY, STATE, ZIP TELEPHONE NUMBER ( )

This form is provided with:

☐ Contract ☐ Proposal ☐ Request for Proposal ☐ Invitation to Bid ☐ Grant Proposal

Have you or any of your partners, divisions, or any related business units previously performed work or provided goods to any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify below the State Agency/Department that received the goods or services, the type(s) of goods or services previously provided, and the amount received for the provision of such goods or services.

STATE AGENCY/DEPARTMENT	TYPE OF GOODS/SERVICES	AMOUNT RECEIVED

Have you or any of your partners, divisions, or any related business units previously applied and received any grants from any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify the State Agency/Department that awarded the grant, the date such grant was awarded, and the amount of the grant.

STATE AGENCY/DEPARTMENT	DATE GRANT AWARDED	AMOUNT OF GRANT

1. List below the name(s) and address(es) of all public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF PUBLIC OFFICIAL/EMPLOYEE	ADDRESS	STATE DEPARTMENT/AGENCY

OVER

2. List below the name(s) and address(es) of all family members of public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the public officials/public employees and State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF FAMILY MEMBER	ADDRESS	NAME OF PUBLIC OFFICIAL/ PUBLIC EMPLOYEE	STATE DEPARTMENT/ AGENCY WHERE EMPLOYED

If you identified individuals in items one and/or two above, describe in detail below the direct financial benefit to be gained by the public officials, public employees, and/or their family members as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

Describe in detail below any indirect financial benefits to be gained by any public official, public employee, and/or family members of the public official or public employee as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

List below the name(s) and address(es) of all paid consultants and/or lobbyists utilized to obtain the contract, proposal, request for proposal, invitation to bid, or grant proposal:

NAME OF PAID CONSULTANT/LOBBYIST	ADDRESS

By signing below, I certify under oath and penalty of perjury that all statements on or attached to this form are true and correct to the best of my knowledge. I further understand that a civil penalty of ten percent (10%) of the amount of the transaction, not to exceed $10,000.00, is applied for knowingly providing incorrect or misleading information.

Signature Date

Notary's Signature Date Date Notary Expires

Act 2001-955 requires the disclosure statement to be completed and filed with all proposals, bids, contracts, or grant proposals to the State of Alabama in excess of $5,000.

7.17 Appendix Q - AMMIS Enhancements

The Vendor shall be required to manage the following requirements in accordance with *Section 2.04 Enhancement Implementation Phase (EIP) - Statement of Work.*

Req. #	Requirement
	Miscellaneous Enhancements
3.01.165	The Vendor shall recommend cost savings proposals to the Agency as described in Appendix M of this ITB.
3.02.121	The Vendor shall provide staffing levels for the PAC and EMC to achieve an average of two and a half minute or less hold time with an 8.5% or less abandonment rate after fifteen (15) seconds. Therefore, an answer rate of 91.5% or greater has been targeted.
3.02.122	The Vendor shall use USPS approved software to convert the Provider mail to address in the PMF to conform with standardized USPS regulations. This includes adding Zip + 4.
3.01.115	The Vendor shall perform cycle monitoring, internal team meetings, software configuration management, release management and all quarterly and annual reoccurring file updates (including SURS control files or equivalent functionality) as system maintenance tasks. These tasks will not be billable or use system modification hours.
3.01.172	The Vendor shall comply with all federal HIPAA Privacy and Security Rules as if the Vendor was a covered entity.
3.01.173	The Vendor shall designate a Privacy Officer and Security Officer. One individual may serve in the capacity of both Privacy and Security Officer. The Vendor shall obtain Agency approval of their Privacy and Security Officer designee(s).
3.01.174	The Vendor shall perform a bi-annual technical and nontechnical security evaluation based on the standards outlined in 45 CFR Part 164, Subpart C, Security Standards for the Protection of Electronic Protected Health Information, on or before December 31st. The evaluation shall be considered system maintenance.
3.01.175	The Vendor shall correct all deficiencies identified by the security evaluation to bring the Vendor into compliance with the HIPAA Security Rule. The correction of the deficiencies shall be considered system maintenance.
3.01.176	The Vendor shall present a plan of action for correcting all deficiencies found during the security evaluation within thirty 30 (thirty) days of completing the evaluation. The plan of action shall include processes and estimated completion dates. The plan must be approved by the Agency before it is implemented. The production of the plan shall be considered system maintenance.
3.01.177	The Vendor shall within 30 (thirty) days of the date of completing the HIPAA security evaluation provide the Agency a copy of the security evaluation report. The Agency reserves the right to share the contents of the security evaluation report with other entities as deemed necessary in the furtherance of the objectives of the Agency.
3.01.178	The Vendor shall notify the Agency no later than one (1) business day following the discovery of a breach of Protected Health Information (PHI).
3.01.179	The Vendor shall provide the following information and obtain Agency approval prior to reporting a breach as required by 45 CFR Part 164, Subpart D: - The number of recipient records involved in the breach. - A brief description of what happened, including the date of the breach and the date of the discovery of the breach if known. - A description of the types of unsecure protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other type information were involved).

Req. #	Requirement
	- Any steps the individuals should take to protect themselves from potential harm resulting from the breach. - A brief description of what the Vendor is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches. - Contact procedures for individuals to ask questions or learn additional information, which shall include the Vendor's toll-free number, email address, Web site, or postal address. - A proposed media release developed by the Vendor.
3.01.180	After Agency approval, the Vendor shall provide the necessary notices to the recipient, prominent media outlet, or the Secretary of Health and Human Services (HHS) to report Vendor breaches as required by 45 CFR Part 164, Subpart D.
3.01.181	The Vendor shall pay all fines or penalties imposed by HHS under 45 CFR Part 160 HIPAA Administrative Simplification: Enforcement rule for breaches made by any employee, officer, or agent of the Vendor.
3.01.182	The Vendor shall pay all costs associated with notifying the Agency, recipients, media outlets, and HHS for breaches made by any employee, officer, or agent of the Vendor.
	Document Repository Enhancement - these changes will provide an audit trail of modifications to project documents, map the 2004 ITB requirements to the 2011 ITB requirements and continue to maintain the requirements throughout the contract to reflect the current state of the AMMIS.
3.01.143	The repository used for the project documents and documentation must have an audit trail and versioning for all documents. This would capture date changed and changed by. It shall also retain a minimum of ten (10) previous versions.
3.01.166	The Vendor shall update all iTRACE documentation to reflect the new ITB Requirements and numbering.
3.01.167	The Vendor shall update all other documentation which currently references prior ITB Requirements and numbering with the new ITB Requirements and numbering.
3.01.168	The Vendor shall identify all change orders implemented which have resulted in additional or modified system functionality and draft new system requirements to reflect those changes for Agency approval by September 1, 2011.
3.01.169	The Vendor shall, as part of the implementation of all change orders or defects, identify and update the associated requirement(s). If there are no requirements for this change, the Vendor shall write the new requirement(s). The new or updated requirement(s) shall be submitted to the Agency for approval prior to implementation.
3.01.170	The Vendor shall as part of the implementation of any change orders or defects, update all other documentation with the new or updated requirement(s) and requirement(s) numbering. The modified documents must be presented to the Agency for approval prior to implementation.
	Security Enhancement - This piece of hardware will allow the Vendor to destroy the data from all media types. This is required for security regulation compliance.
3.01.140	The Vendor shall have an in-house degausser for all media types received and/or maintained by the Vendor.
	HIPAA 5010 electronic transaction Enhancement - The Code of Federal Regulations (CFR) has been revised to require the use of the following transaction and code sets effective 01/01/2012: ASC X12N 005010 with applicable Errata National Council for Prescription Drug Programs (NCPDP) D.0/Batch 1.2 NCPDP Batch 3.0 for Medicaid Subrogation of Pharmacy Claims (New Transaction)

Req. #	Requirement
3.01.013	The system shall be modified to process HIPAA EDI transactions in the ASC X12 4010 format and the ASC X12 5010 format concurrently. This shall allow the Agency to discontinue the use of ASC X12 4010 transactions with an automated error message being returned to the sender. The fiscal agent shall identify all vendors using 4010 transactions and generate notices announcing discontinuation of ASC X12 4010 support in advance of the discontinuation. The date for production of said notices shall be determined by the Agency.
3.01.014	The system shall be modified to process HIPAA EDI NCPDP 5.1 (interactive) and NCPDP 1.1 (batch) concurrently with HIPAA EDI NCPDP D.0 (interactive) and NCPDP 1.2 (batch) transactions concurrently. This shall allow the Agency to discontinue the use of NCPDP 5.1 and NCPDP 1.1 transactions with an automated error message being returned to the sender. The fiscal agent shall identify all vendors using NCPDP 5.1 and NCPDP 1.1 transactions and generate notices announcing discontinuation of NCPDP 5.1 and NCPDP 1.1 support in advance of the discontinuation. The date for production of said notices shall be determined by the Agency.
3.01.015	The MMIS shall be fully capable of processing, displaying, searching and reporting all data fields from all NCPDP and ASC X12 5010 transactions in all panels, reports, processes, etc. All fields, reports or processes, etc. currently using ICD-9 codes shall be capable of using ICD-10 codes without modification.
3.01.150	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Claims/Encounter transactions in the HIPAA X12N 4010 X098A1 (837 P), X12N 4010 X097A1 (837 D), X12N 4010 X096A1 (837 I) and the HIPAA2 X12N 5010 X222 E1 (837 P), X12N 5010 X224A1 E1 (837 D), X12N 5010 X223A1, E1 (837 I) formats.
3.01.151	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive remittance advice in the HIPAA X12N 4010 X091A1 (835) and the HIPAA2 X12N 5010 X221E1 (835) formats.
3.01.152	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive eligibility inquiries and responses in the HIPAA X12N 4010 X092A1 (270/271) and the HIPAA2 X12N 5010 X279E1 (270/271) formats.
3.01.153	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive benefit enrollment and maintenance transactions in the HIPAA X12N 4010 X095A1 (834) and the HIPAA2 X12N 5010 X220E1 (834) formats.
3.01.154	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive premium payment transactions in the HIPAA X12N 4010 X061A1 (820) and the HIPAA2 X12N 5010 X218E1 (820) formats.
3.01.155	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Authorization and Referral Request and Response (Non-Pharmacy) transactions in the HIPAA X12N 4010 X094A1 (278) and the HIPAA2 X12N 5010 X217E1, E2 (278) formats.
3.01.156	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Claim Status Inquiry and Response transactions in the HIPAA X12N 4010 X093A1 (276/277) and the HIPAA2 X12N 5010 X212E1, E2 (276/277) formats.
3.01.157	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Pharmacy Claim /Encounter transactions in the HIPAA NCPDP 5.1 (interactive), NCPDP 1.1 (batch) and NCPDP D.0 (interactive), NCPDP 1.2 (batch) formats.
3.01.158	The Vendor shall modify the MMIS (including TPL) to transmit and receive Pharmacy Supplies and Professional Services Claim/Encounter transactions in the HIPAA X12N 5010 X222E1 (837P) or NCPDP D.0 (interactive) and NCPDP 1.2 (batch) formats.

Req. #	Requirement
3.01.159	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Pharmacy Eligibility Inquiry and Response transactions in the HIPAA NCPDP 5.1 (interactive), NCPDP 1.1 (batch) and the HIPAA2 NCPDP D.0 (interactive), NCPDP 1.2 (batch) formats.
3.01.160	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Pharmacy Authorization and Referral Request and Response (Retail Pharmacy) transactions in the HIPAA NCPDP 5.1 (interactive), NCPDP 1.1 (batch) and the HIPAA2 NCPDP D.0 (interactive), NCPDP 1.2 (batch).
	ICD-10 Impact Assessment - The transition from ICD-9 to ICD-10 has an effective date of 10/1/2013. This transition will not be included in this ITB, but an impact assessment will be required. The impact assessment will identify the changes required to the AMMIS to receive the maximum benefits from this transition.
3.01.163	The Vendor shall provide an analysis to the highest specificity of the impacts that result with the transition from the ICD 9 to ICD 10. The analysis shall include but not be limited to: - new code to similar code/deleted code, - age, - gender - BPA (Benefit Plan Administration) - recipient plan - edits/audits - diagnosis groups and ICD Surgical procedure groups - crosswalks of all system and adhoc reports that utilize ICD codes - all other impacted portions of the AMMIS All field lengths for ICD-10 shall match system wide. The Vendor shall provide an impact statement to the Agency during the Analysis phase of the Design, Development and Implement phase.
3.04.016	The Vendor shall provide an Annual analysis to the highest specificity of the impacts that result from the ICD 9/10 Diagnosis and Surgical Procedure code updates. The analysis shall include but not be limited to: - new code to similar code/deleted code - age, - gender - BPA (Benefit Plan Administration) - recipient plan - edits/audits - diagnosis groups and ICD Surgical procedure groups The Vendor shall provide the analysis to the Agency by the first business day of September.
3.04.015	The Vendor shall, without notification from the Agency, retrieve from the CMS website the annual ICD-9/10, Diagnosis and Surgical procedure codes. The information is available in August and will be applied by Sept 15th with an effective date of Oct 1st to the highest level of specificity.
	Provider Enrollment/Re-enrollment Enhancement - these changes will require the Vendor to re-enroll all providers every five (5) years and to re-enroll targeted providers every year. The Vendor will be required to closely monitor the Durable Medical Equipment (DME) providers and home health providers with onsite verification performed for each enrolling/re-enrolling DME provider.

Req. #	Requirement
3.02.118	Prior to enrollment the vendor shall verify through on-site visits that durable medical equipment (DME) provider applicants have fully functional locations and meet the requirements specified in the Alabama Medicaid Administrative Code Chapter 13 and the Provider Billing Manual.
3.02.119	The Vendor shall establish provider end date for home health and durable medical equipment (DME) enrollees as the date their current business license expires. The Vendor shall conduct re-enrollment prior to license expiration and in accordance with initial enrollment process.
3.02.120	The Vendor shall conduct re-enrollment of all providers, except home health and DME, every five (5) years. The Provider re-enrollment shall include Patient 1st re-enrollment. The initial re-enrollment shall occur during the first year of operations.
3.02.054	The Vendor shall maintain provider enrollment personnel with a minimum of ten (10) FTEs - Enrollment Specialists, one (1) FTE - Quality Assurance, and one (1) FTE Enrollment Supervisor.
3.02.071	The Vendor shall store all provider enrollment call center, provider representative call center, and provider assistance call center recordings in a secured area accessible by the Agency. All calls from these Call Centers shall be retained for a minimum of twelve (12) months. The Vendor shall work with the Agency to define search criteria to easily locate specific calls. The search criteria shall include, but not be limited to call date, time, phone number the call originated from, Provider name, Provider ID or call identifier, and the Call Center worker. If requested, the Vendor shall provide the Agency with a copy of the voice recording within one (1) hour of request.
3.02.114	The Vendor shall maintain a 99.8% accuracy rate for processing provider applications and entering information into the system. 99.8% accuracy applies to the following data fields: - All Provider Names - Provider ID (NPI) - Provider Addresses (All to include city, county, state, 9-digit zip code, service location, pay to, mail to and home office) - Telephone/Fax Numbers - License Number - SSN - CLIA Number - Contract effective and end dates - Primary Contact name If the accuracy rate falls below 99.8%. The Vendor shall develop and submit to the Agency for approval a performance improvement plan within five (5) days of notification of deficiency. The plan must be implemented within five (5) days of approval by the Agency. If the plan does not correct the deficiency within three (3) months a revised plan must be submitted and approved.
3.02.134	The Vendor shall provide on a monthly basis operational reports from the provider enrollment staff, provider representative staff, and provider assistance center about the types of inquiries received during the month, by hour segment and day. The monthly reports shall cover the previous month's activity and be provided no later than the 5th day of the month. The Vendor shall work with the Agency to define the types of inquiries to be tracked.
	Provider Web Application - these changes will add functionality to the Vendor's Provider web. The changes will allow providers to submit enrollment and update information via the Web with real-time validation of the data entered.
3.02.123	The Vendor shall develop a secured web application that allows Providers to submit all required information on the enrollment/re-enrollment applications and make Agency defined changes to the Provider's information.

Req. #	Requirement
3.02.124	The Vendor's provider web application shall allow the Providers to update selected information. The Vendor shall work with the Agency to identify the information Providers are allowed to update. The information Providers are allowed to update through the web application will not require a provider signature page.
3.02.125	The Vendor shall define a process to report statistics associated with the provider web portal. The process and statistics reported must be approved by the Agency. The statistics will include but not be limited to the performance measures, provider usage and application errors associated with the provider web application.
3.02.126	The Vendor's provider web application will edit the provider application entry and update fields for presence, validity and formatting when possible. The field validation will use data that is maintained in the AMMIS and return applicable error messages on-line real-time. Enrollment information that is not maintained in the AMMIS shall be validated and a response returned to the Provider within five (5) days of entry. Update information that is determined to be incorrect or in error shall be returned to the Provider within two (2) days of entry.
3.02.127	The Vendor's provider web application shall validate the Provider mailing and physical (service location) addresses using USPS approved software. The zip + 4 will be validated if entered or added at time of entry if not supplied by the Provider.
3.02.128	The Vendor's provider web application shall use the Managed Care defined process to identify or validate the Provider county based on the service location.
3.02.129	The Vendor shall capture all information entered in the Provider web portal. The information shall be stored in the Provider Master File or another location approved by the Agency.
3.02.130	The Vendor's provider web application shall provide the capability to print the entire application form with the information entered by the Provider. The Provider will be informed that they must print and sign specified signature pages. These signature pages and any other documents requested shall be mailed to the address indicated and received by the Vendor within ten (10) days of entry.
3.02.131	The Vendor's provider web application shall create a facsimile in the electronic document database for every electronically submitted enrollment application or update. The Vendor shall assign tracking numbers to all facsimiles. The Vendor shall store the documents in a method that allows for search by Provider name and Provider number, if assigned.
3.02.132	The Vendor shall develop a plan to educate the providers on the new web based enrollment and update application. The Provider education plan shall be submitted to the Agency for approval. The Vendor shall begin implementing the Agency approved Provider education plan within an Agency approved time frame.
3.02.133	The Vendor's Provider enrollment staff shall support all Provider inquiries on the Provider enrollment and update web application.
	Recipient Claim History Enhancement - These changes will provide a report from the AMMIS that contains a history of a recipients claims. This report will be used by the Agency to verify a recipient's claims and correct any errors.
3.03.047	The Vendor shall maintain a process to generate recipient claim history requests and show all claims, adjustments, and financial transactions that have occurred for the selection parameters requested. The process shall access all claims history and all claim types. The reports shall be produced within one (1) day of the request and shall be printed on single-sided paper and delivered to the Agency in the standard mail run. Due to the one day turn-around requirement, the reports shall be produced from the MMIS (DSS is not updated nightly). The reports shall be produced by recipient (including merged recipient ID numbers) not claim type. The report shall include a description of procedure, drug, diagnosis, error codes and provider name.

Req. #	Requirement
	Recipient Web Portal Enhancement - The Vendor will be required to expand the current functionality of the recipient web portal. These enhancements will allow recipients to update selected information.
3.03.116	The Vendor shall provide an Alabama Medicaid Interactive Web Site which requires an entry of the Recipient ID and their Date of Birth to access a Recipient's data.
3.03.117	The Vendor shall provide an Alabama Medicaid Interactive Web Site which allows Recipients the option to report changes via the web. The recipient web application shall allow the recipient to print an Agency approved change form and provide a Vendor e-mail, a Vendor fax number and a Vendor mailing address for form submission. The Vendor shall update the AMAES application within one (1) day of receipt of the change from the web, fax, e-mail or mail. This applies to updates referenced in Requirements 3.03.077, 3.03.078, 3.03.119, 3.03.122, & 3.03.123.
3.03.118	The Alabama Medicaid Interactive Web Site shall provide in response to the Recipient entering their Recipient ID and Date of Birth the following information: - Recipient Name - Recipient Status (Active or Inactive) - Patient 1st Doctor Name, Address and Telephone Number. The Recipient status if active shall identify the "through date".
3.03.119	The Alabama Medicaid Interactive Web Site shall allow Recipients to view available Providers based on provider enrollment criteria such as but not limited to number of current patients or proximity to the Recipient's location. The Recipient shall be able to select a Patient 1st Provider from the list of available Providers. At the time of the selection, the web application shall notify the recipient of the effective date for the selected Provider.
3.03.120	The Alabama Medicaid Interactive Web Site shall allow the Recipient to request a replacement card. The Vendor shall issue replacement cards in accordance with current Agency policy. The web application shall allow recipients to print the Agency approved Medical Services Eligibility Verification (MSEV) form.
3.03.121	The Alabama Medicaid Interactive Web Site shall provide the Recipient with benefit limits used and benefits available for those services for which they are eligible. The benefit used and available shall identify the "as of date".
3.03.122	The Alabama Medicaid Interactive Web Site shall allow the recipient to submit an Agency approved change request on-line real-time. The change request shall allow the recipient to change the following information: - Address - Home Phone with Area Code - Cell Phone - E-mail Address - Marital Status - Sponsor Address - Family Changes, - Income Changes, - Expense Changes, - Insurance Changes, - Report of Death, - Ability to close a Medicaid Account or withdraw an Application, and - A free text area to enter other change information with an effective date for the change. The Vendor shall receive the information entered on the web and make the changes in the AMAES application within one (1) day of receipt.

Req. #	Requirement
3.03.077	The Vendor shall update eligibility file change requests received via phone and/or web application to change name, address, sex code, phone number, county code, marital status, and/or race for MLIF, SOBRA, and Plan First certified cases.
3.03.078	The Vendor shall update the eligibility file change requests received via phone and/or web application to change address, phone number, and marital status of the beneficiary and update sponsor's address and phone number for District Office (Elderly & Disabled) certified cases. For marital status changes, the spouse's name, address, SSN & DOB must be verified.
3.03.070	The Vendor shall provide application status (pending=P; awarded =A; denied=D; and terminated =T) to applicants. For pending cases (if application was received less than forty-five (45) days from the date of the call, the Call center Representative shall check the file to see if the application shows up in the system as pending. If so, respond that the case is pending. If it does not show up in the system, respond that Medicaid has forty-five (45) days to process a case and the application may not have been entered into the system yet. Advise them to check back in 7-10 days. If the application was received more than forty-five (45) days from the date of the call, then refer to the assigned caseworker using the caseworker file to look up the workers name and phone number. For denied cases then refer to the assigned caseworker using the caseworker file to look up the worker's name and phone number. For terminated cases instruct the individual to complete another application [mail the appropriate applications to the individual and/or direct them to the web application]).
	Drug Maintenance Enhancement - These changes will require the Vendor to assume the support and maintenance of the drug data warehouse. The Vendor will contract directly with a drug data warehouse vendor to provide periodic updates. The Vendor will be responsible for all maintenance and reporting associated with the drug data warehouse. The Vendor will enhance the Provider web portal to include a drug look-up function.
3.04.073	The Vendor shall maintain license agreement on behalf of the Agency with the data warehouse. The license agreement shall accommodate the average monthly claim count of 200,000 to 2 million. At the time of writing this ITB, the Agency averages 600,000 pharmacy claims per month (FY08).
3.04.076	The Vendor shall provide a drug look up system for providers to sign into and look up prices and coverage (e.g., PA status, PDL status) information for specific NDC's. The Vendor shall obtain Pharmacy Service staff approval of the drug lookup system.
3.04.083	The Vendor shall maintain any drug information provided by the data warehouse that is currently not used in the Reference subsystem.
3.04.084	The Vendor shall provide a staff member as the primary contact for the Agency concerning the drug data warehouse. The Vendor shall provide a backup point of contact should the primary liaison be unavailable. The Vendor's point of contact for the drug data warehouse responsibilities shall include, but are not limited to: • Assist the Agency with any data warehouse related questions. • Contact the data warehouse to verify any information related to the drug file. • Return messages/correspondence from the Agency within one business day. • Meet with Agency staff upon request.
3.04.085	The Vendor shall ensure that the drug data warehouse identifies a primary and secondary point of contact. The Agency must have the ability to contact the data warehouse directly without contacting the Vendor.

Req. #	Requirement
	E-Prescribing Enhancement - The Vendor will build the e-prescribing functionality within the AMMIS. As a result of these changes, participating physicians will have a comprehensive view of recipient eligibility and medication histories across all participating payers.
3.04.119	The Vendor shall make available to SureScripts-RxHub the following information which shall be available to Alabama e-prescribers with SureScripts-RxHub access: • Eligibility information• Medication histories • Benefit plan details, such as - Preferred Drug List - Prior Authorizations - Co-payments - Dosages - Drug Utilization Reviews - Quantity Limitations.
3.04.120	The Vendor shall ensure transactions to Alabama's MMIS are received from SureScripts-RxHub, so that recipient eligibility and medication history data can be exchanged.
3.04.121	The Vendor shall configure the AMMIS to respond to SureScripts-RxHub e-prescribing requests.
3.04.122	The Vendor shall provide SureScripts-RxHub with the Agency's drug PDL and benefit information by providing data files that break down the Agency's drug benefit and policy rules into the following categories: • PDL Status • Drug Classification • Coverage Text Message • Product Coverage Exclusion • Prior Authorization • Quantity Limits • Age Limits • Gender Limits • Resource Link • Benefit Co-pay • Cross-Reference Detail Updates to any of these categories shall be sent to SureScripts-RxHub within twenty-four (24) hours of notification by the Agency.
3.04.123	The Vendor shall provide SureScripts-RxHub with the preferred status of the Agency drugs. The Agency currently supports one PDL listing for all benefit groups.
3.04.124	The Vendor shall create a new AMMIS on-line panel to support drug classifications. This panel shall allow a user to enter a drug, GFC (Generic Formula Code), or list where an alternatives class ID or subclass ID can be listed. These rules shall be based on a recipient's eligibility program to allow flexibility that drug classifications can be different among programs. The Vendor shall extract all active drug classification rules and send them to SureScripts-RxHub along with the drug classification ID, which associates the drug data with a recipient's program.
3.04.125	The Vendor shall create a new AMMIS on-line panel to support specific NDC related text messages. This panel shall allow a user to enter a National Drug Code (NDC), Generic Formula Code (GFC), or list along with a two hundred (200) character text message. The Vendor shall extract all active text message rules and send them to SureScripts-RxHub. This transaction shall allow specific messages to be conveyed about particular drugs.
3.04.126	The Vendor shall transmit a product coverage exclusion transaction which allows exclusion criteria related to an NDC to be returned to SureScripts-RxHub. Products for nonparticipating manufacturers shall be returned in this transaction, specific to the eligibility program that is applicable.
3.04.127	The Vendor shall return current, active, payable NDCs requiring prior authorization (PA). This shall provide SureScripts-RxHub with all the current drugs where a PA is

Req. #	Requirement
	required, based on the PA indicator on the Agency's drug file.
3.04.128	The Vendor shall allow NDCs to be returned in the extract file when the NDC has a quantity limit. All records sent to SureScripts-RxHub shall be NDC-specific, and the data provided shall include the drug, maximum quantity, and time period associated with the quantity.
3.04.129	The Vendor shall return each current, active, payable NDC with an age restriction. This shall provide SureScripts-RxHub with all the current drugs where age restrictions are applicable, based on the age criteria on the Agency's drug file. This transaction can specifically address recipient fraud if the same names are used between generations and only the children qualify for the program.
3.04.130	The Vendor shall return each current, active, payable NDC with a gender restriction. This shall provide SureScripts-RxHub with all the current drugs where gender restrictions are applicable, based on the gender criteria on the Agency's drug file.
3.04.131	The Vendor shall provide the capability for a Web link to be returned to SureScripts-RxHub in the extract file. Web links are useful for providing a pathway to prescribers for forms or information that may be needed during the prescription-generating processes. For example, links to prior authorization forms are provided when the forms are required to prescribe certain prescriptions. There are two types of resource link transactions. There is a resource link summary transaction and a resource link drug-specific transaction. For each transaction, a resource link "type" shall indicate the type of information being conveyed. There are ten types of resource links allowed: Age Limit, Product Coverage Exclusion, Gender Limits, Medical Necessity, Prior Authorization, Quantity Limits, Step Therapy, General Information, Co-pay, and Formulary. The resource link drug-specific transaction is associated with a drug where the summary transaction is not. Updates to resource links shall be part of system maintenance.
3.04.132	The Vendor shall allow specific Agency co-pay rules to be returned. These rules shall be based on a recipient's eligibility program to allow reporting flexibility for the different programs. Although Agency policy currently supports one co-payment based on the cost of the medication, this functionality shall provide a means of communicating to the practitioner whether a tiered co-payment would be applied if Agency policy changes, based on the flexibility allowed with the passage of the Deficit Reduction Act.
3.04.133	The Vendor shall create a new AMMIS on-line cross-reference detail panel to support the recipient's formulary and benefit information. This panel shall allow a user to enter a health plan name associated with an aid category list, alternative ID, coverage ID, co-pay list ID, and classification ID. All this information shall be used to support the interactive eligibility request that is sent through SureScripts-RxHub. This panel ties a recipient's benefit information together and allows a prescriber to access the recipient's benefit information.
3.04.134	The Vendor shall provide SureScripts-RxHub the Agency's recipient information from the AMMIS. The Vendor shall send a one-time master file, followed by nightly updates based on changes to recipient data. The information shall be sent in the SureScripts-RxHub file layout along with all the data elements being requested. SureScripts-RxHub shall use these files to establish uniqueness for recipients among the different third-party vendors.

Req. #	Requirement
3.04.135	The Vendor shall provide a recipient's prescription medication history to SureScripts-RxHub from the AMMIS via the current NCPDP Script medication history transaction format. This transaction allows the flexibility for up to fifty (50) paid history prescriptions to be returned to a valid Agency provider/prescriber. The number of claims returned in the response shall be based on the number of prescriptions the recipient has in history, the age of the claims, and ensuring adequate response times. Paid prescription data within a specified time period shall be gathered from the AMMIS and returned in this transaction, based on SureScripts-RxHub's data requirements. The Vendor shall optimize response times so that response time does not limit the maximum number of scripts that are returned.
3.04.136	The Vendor shall modify the 270 and 271 eligibility request and response transactions to provide additional information to SureScripts-RxHub specific to a recipient's benefit and PDL information. Additional processing rules, within the HIPAA guidelines, are requested to support SureScripts-RxHub's processing. These processing rules shall be incorporated into this transaction to aid SureScripts-RxHub. The PDL and benefit load information shall be retrieved from the new AMMIS on-line panel under this cross-reference detail transaction. By using the benefit IDs returned in this transaction, a prescriber can access a recipient's PDL information through SureScripts-RxHub.
3.04.137	The Vendor shall report transactions for requested recipient eligibility and medication history data on a monthly basis. The Vendor shall include reporting data for point-of-care (POC) technology vendor participation, transaction performance, and trending analysis for e-prescribing adoption and use. There are two main data sources for the transactions statistics—one from SureScripts-RxHub and the other from the AMMIS system. The information from both sources shall be combined to present reports that summarize all the available data. Reports shall be provided to the Agency the 5th day of the month.
3.04.138	The Vendor shall report prescription-related counts and related information as data becomes available
3.04.139	The Vendor shall make available through the existing WEB Portal the ability to perform full electronic prescribing capabilities. Interactive, real-time patient data should enable full clinical decision support and electronic transmission to any pharmacy in the SureScripts network. The ePrescribing module shall be fully certified with the SureScripts Health Information Network and enrolled Medicaid providers should have the ability to service all of their current and future patients. The provider portal should offer a no-cost option, assuming the provider has access to the Internet at their office.
	CCI (Correct Coding Initiatives) Enhancement - This enhancement will automate the process of applying the CMS quarterly CCI updates to the AMMIS.
3.01.088	Contract required personnel for the Operations Phase of the contract include: EIS/DSS Technical support, Customer Relations staff, EMC Coordinator, Modification Teams, HCPCS Coordinator, SURS Analyst, TCM (Targeted Case Management) Prior Authorization Coordinator, Medical Policy Specialist, Quality Assurance Manager, Provider Quality Assurance Evaluator, Systems/Technical Support and a total of two (2) Medical Policy Analysts of which one (1) shall be a Registered Nurse in the State of Alabama and a Certified Professional Coder (CPC) through the American Academy of Professional Coders and the other shall be at a minimum a Certified Professional Coder (CPC) through the American Academy of Professional Coders.
3.04.143	The Vendor shall implement Correct Coding Initiatives (CCI) Edits for physician and outpatient hospital claims in accordance with CMS guidelines. The Vendor shall meet with the Agency prior to the initial implementation of the CCI Edits to identify those applicable to the Alabama Medicaid Agency.

Req. #	Requirement
3.04.144	The Vendor shall subscribe to CMS quarterly updates for the CCI Edits. CMS sends notifications quarterly of the changes to the CCI Edits. The Vendor shall meet with the Agency within five (5) days of the CMS email notification to determine the CCI Edits applicable to the Agency. The Vendor shall implement the Agency approved CCI Edits within ten (10) days of obtaining Agency approval.
3.04.145	The Vendor shall review all CCI edits identified and provide end to end test results to ensure edits are working properly prior to implementation. This shall include regression testing.
3.06.075	The Vendor shall perform all data processing operations to support Claims/Encounter processing requirements, including: - On-line real-time Edit/Audit processing including Correct Coding Initiatives (CCI) Edits; - Suspense resolution; - On-line real-time Claim pricing; and - On-line real-time Adjudication processing.

7.18 Appendix R - MITA Maturity Matrix

The spreadsheet below represents the results of the Agency's MITA State Self Assessment which was completed December 2009.

MITA BUSINESS AREA	ALABAMA BUSINESS AREA	MITA BUSINESS PROCESS	ALABAMA BUSINESS PROCESS	AS IS LEVEL OF BUSINESS CAPABILITY	TO BE LEVEL OF BUSINESS CAPABILITY
Member Management					
Member Management	Member Management	ME Determine Eligibility	ME01 Determine Eligibility	1	1
Member Management	Member Management	ME Enroll Member	ME02 Enroll Member	1	1
Member Management	Member Management	ME Disenroll Member	ME03 Disenroll Member	1	1
Member Management	Member Management	ME Inquire Member Eligibility	ME04 Inquire Member Eligibility	1	1
Member Management	Member Management	ME Manage Application & Member Communication	ME05 Manage Application & Member Communication	1	1
Member Management	Member Management	ME Manage Member Grievance and Appeal	ME06 Manage Member Grievance and Appeal	1	1
Member Management	Member Management	ME Manage Member Information	ME07 Manage Member Information	1	1
Member Management	Member Management	ME Manage Population and Member Outreach	ME08 Manage Population and Member Outreach	1	1
Provider Management					
Provider Management	Provider Management	PM Enroll Provider	PM01 Enroll Provider	1	1
Provider Management	Provider Management	PM Disenroll Provider	PM02 Disenroll Provider	1	1
Provider Management	Provider Management	PM Inquire Provider Information	PM03 Inquire Provider Information	1	1
Provider Management	Provider Management	PM Manage Provider Communication	PM04 Manage Provider Communication	1	1

MITA BUSINESS AREA	ALABAMA BUSINESS AREA	MITA BUSINESS PROCESS	ALABAMA BUSINESS PROCESS	AS IS LEVEL OF BUSINESS CAPABILITY	TO BE LEVEL OF BUSINESS CAPABILITY
Provider Management	Provider Management	PM Manage Provider Grievance & Appeal	PM05 Manage Provider Grievance & Appeal	1	1
Provider Management	Provider Management	PM Manage Provider Information	PM06 Manage Provider Information	1	1
Provider Management	Provider Management	PM Perform Provider Outreach	PM07 Perform Provider Outreach	1	1
Contractor Management					
Contractor Management	Contractor Management	CO Produce Administrative or Health Services RFP	CO01 Produce Administrative or Health Services RFP	1	1
Contractor Management	Contractor Management	CO Award Administrative or Health Services Contract	CO02 Award Administrative or Health Services Contract	1	1
Contractor Management	Contractor Management	CO Manage Administrative or Health Services Contract	CO03 Manage Administrative or Health Services Contract	1	1
Contractor Management	Contractor Management	CO Close-out Administrative or Health Services Contract	CO04 Close-out Administrative or Health Services Contract	1	1
Contractor Management	Contractor Management	CO Manage Contractor Information	CO05 Manage Contractor Information	1	1
Contractor Management	Contractor Management	CO Manage Contractor Communication	CO06 Manage Contractor Communication	1	1
Contractor Management	Contractor Management	CO Perform Contractor Outreach	CO07 Perform Contractor Outreach	1	1
Contractor Management	Contractor Management	CO Support Contractor Grievance and Appeal	CO08 Support Contractor Grievance and Appeal	1	1
Contractor Management	Contractor Management	CO Inquire Contractor Information	CO09 Inquire Contractor Information	1	1
Operations Management					

MITA BUSINESS AREA	ALABAMA BUSINESS AREA	MITA BUSINESS PROCESS	ALABAMA BUSINESS PROCESS	AS IS LEVEL OF BUSINESS CAPABILITY	TO BE LEVEL OF BUSINESS CAPABILITY
Operations Management	Operations Management	OM Authorize Referral	OM01 Authorize Referral	N/A	N/A
Operations Management	Operations Management	OM Authorize Service	OM02 Authorize Service	1	2
Operations Management	Operations Management	OM Authorize Treatment Plan	OM03 Authorize Treatment Plan	N/A	N/A
Operations Management	Operations Management	OM Apply Attachment	OM04 Apply Attachment	1	1
Operations Management	Operations Management	OM Apply Mass Adjustment	OM05 Apply Mass Adjustment	1	1
Operations Management	Operations Management	OM Edit Claim/Encounter	OM06 Adjudicate and Price/Value Claim/Encounter*	1	1
Operations Management	Operations Management	OM Audit Claim/Encounter	OM07 Adjudicate and Price/Value Claim/Encounter*	1	1
Operations Management	Operations Management	OM Price Claim/Value Encounter	OM08 Adjudicate and Price/Value Claim/Encounter*	1	1
Operations Management	Operations Management	OM Prepare Remittance Advice/Encounter Report	OM09 Prepare Remittance Advice/Encounter Report	2	2
Operations Management	Operations Management	OM Prepare Provider EFT/Check	OM10 Prepare Provider EFT/Check	1	1
Operations Management	Operations Management	OM Prepare COB	OM11 Prepare COB	N/A	N/A
Operations Management	Operations Management	OM Prepare EOB	OM12 Prepare REOMB	1	1
Operations Management	Operations Management	OM Prepare Home and Community Based Services Payment	OM13 Prepare Home and Community Based Services Payment	2	2
Operations Management	Operations Management	OM Prepare Premium EFT	OM14 Prepare Premium EFT/Check	1	1
Operations Management	Operations Management	OM Prepare Capitation Premium Payment	OM15 Prepare Capitation Premium Payment	1	2

MITA BUSINESS AREA	ALABAMA BUSINESS AREA	MITA BUSINESS PROCESS	ALABAMA BUSINESS PROCESS	AS IS LEVEL OF BUSINESS CAPABILITY	TO BE LEVEL OF BUSINESS CAPABILITY
Operations Management	Operations Management	OM Prepare Health Insurance Premium Payment	OM16 Prepare Health Insurance Premium Payment	1	1
Operations Management	Operations Management	OM Prepare Medicare Premium Payments	OM17 Prepare Medicare Premium Payments	1	1
Operations Management	Operations Management	OM Inquire Payment Status	OM18 Inquire Payment Status	2	2
Operations Management	Operations Management	OM Manage Payment Information	OM19 Manage Payment Information	1	1
Operations Management	Operations Management	OM Calculate Spend Down Amount	OM20 Calculate Spend Down Amount	N/A	N/A
Operations Management	Operations Management	OM Prepare Member Premium Invoice	OM21 Prepare Member Premium Invoice	N/A	N/A
Operations Management	Operations Management	OM Manage Drug Rebate	OM22 Manage Drug Rebate	2	2
Operations Management	Operations Management	OM Manage Estate Recovery	OM23 Manage Estate Recovery	1	1
Operations Management	Operations Management	OM Manage Recoupment	OM24 Manage Recoupment	2	2
Operations Management	Operations Management	OM Manage Cost Settlement	OM25 Manage Cost Settlement	1	1
Operations Management	Operations Management	OM Manage TPL Recovery	OM26 Manage TPL Recovery	1	1
Program Management					
Program Management	Program Management	PG Designate Approved Service and Drug Formulary	PG01 Designate Approved Service and Drug Formulary	2	2
Program Management	Program Management	PG Develop & Maintain Benefit Package	PG02 Develop & Maintain Benefit Package	2	2
Program Management	Program Management	PG Manage Rate Setting	PG03 Manage Rate Setting	1	1
Program Management	Program Management	PG Develop Agency Goals & Objectives	PG04 Develop Agency Goals & Initiatives	1	1

MITA BUSINESS AREA	ALABAMA BUSINESS AREA	MITA BUSINESS PROCESS	ALABAMA BUSINESS PROCESS	AS IS LEVEL OF BUSINESS CAPABILITY	TO BE LEVEL OF BUSINESS CAPABILITY
Program Management	Program Management	PG Develop and Maintain Program Policy	PG05 Develop & Maintain Program Policy	1	1
Program Management	Program Management	PG Maintain State Plan	PG06 Maintain State Plan	1	1
Program Management	Program Management	PG Formulate Budget	PG07 Formulate Budget	1	1
Program Management	Program Management	PG Manage FFP for MMIS	PG08 Manage FFP for MMIS	1	1
Program Management	Program Management	PG Manage F-MAP	PG09 Manage F-MAP	1	1
Program Management	Program Management	PG Manage State Funds	PG10 Manage State Funds	1	1
Program Management	Program Management	PG Manage 1099s	PG11 Manage 1099s	2	2
Program Management	Program Management	PG Generate Financial and Program Analysis/Report	PG12 Generate Financial and Program Analysis/Report	1	1
Program Management	Program Management	PG Maintain Benefits/Reference Information	PG13 Maintain Benefits/Reference Information	1	1
Program Management	Program Management	PG Manage Program Information	PG14 Manage Program Information	1	1
Program Management	Program Management	PG Perform Accounting Functions	PG15 Perform Accounting Functions	1	1
Program Management	Program Management	PG Develop and Manage Performance Measures and Reporting	PG16 Develop and Manage Performance Measures and Reporting	1	1
Program Management	Program Management	PG Monitor Performance and Business Activity	PG17 Monitor Performance and Business Activity	1	1
Program Management	Program Management	PG Draw and Report FFP	PG18 Draw and Report FFP	1	1
Program Management	Program Management	PG Manage FFP for Services	PG19 Manage FFP for Services	1	1
Business Management					

MITA BUSINESS AREA	ALABAMA BUSINESS AREA	MITA BUSINESS PROCESS	ALABAMA BUSINESS PROCESS	AS IS LEVEL OF BUSINESS CAPABILITY	TO BE LEVEL OF BUSINESS CAPABILITY
Business Relationship Management	Business Relationship Management	BR Establish Business Relationship	BR01 Establish Business Relationship	1	1
Business Relationship Management	Business Relationship Management	BR Manage Business Relationship	BR02 Manage Business Relationship	1	1
Business Relationship Management	Business Relationship Management	BR Terminate Business Relationship	BR03 Terminate Business Relationship	1	1
Business Relationship Management	Business Relationship Management	BR Manage Business Relationship Communication	BR04 Manage Business Relationship Communication	1	1
Program Integrity					
Program Integrity Management	Program Integrity Management	PI Identify Candidate Case	PIM01 Identify Candidate Case	1	1
Program Integrity Management	Program Integrity Management	PI Manage Case	PIM02 Manage Case	1	1
Care Management					
Care Management	Care Management	CM Establish Case	CM01 Establish Case	1	1
Care Management	Care Management	CM Manage Case	CM02 Manage Case	1	1
Care Management	Care Management	CM Manage Medicaid Population Health	CM03 Manage Medicaid Population Health	1	1
Care Management	Care Management	CM Manage Registry	CM04 Manage Registry	N/A	N/A